PORT SURGEONS AND TROOP MOVEMENT OFFICERS

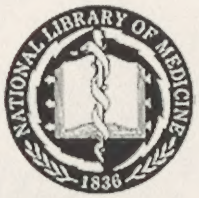
CONFERENCE

N. Y. P. E.

FORT HAMILTON NEW YORK

OCTOBER

1943



L. M. attended this meeting Oct. 14, 1943

CONFERENCE

PORT SURGEONS AND TROOP MOVEMENT OFFICERS

12, 13, 14 October 1943

OFFICE OF THE CHIEF OF TRANSPORTATION

Brig. Gen. Robert H. Wylie	A. U. S.
Col. E. V. Heiskell	T. C.
Lt. Col. Donald E. Farr	T. C.
Maj. Jerry A. Griffin	T. C.

SURGEON GENERAL'S OFFICE

Brig. Gen. Raymond W. Bliss	A. U. S.
Col. Arthur B. Welsh	M. C.
Col. A. H. Schwichtenberg	M. C.
Lt. Col. Paul A. Padan	M. C.
Lt. Col. John C. Fitzpatrick	M. C.
Col. William A. Boyle	M. C.

NEW YORK P.O.E.

Col. George E. Fingarson	G. S. C.
Col. Harry R. Melton	M. C.
Lt. Col. Harold J. Feistel	T. C.
Lt. Col. Henry F. Branstater	T. C.
Lt. Col. George N. Schuhmann	M. C.
Maj. William W. Scheremeta	M. C.
Maj. Herman Axelrod	T. C.

SAN FRANCISCO P.O.E.

Brig. Gen. Wallace DeWitt	M. C.
Col. Melvin L. Craig	G. S. C.
Maj. William J. Quinn	M. C.
Capt. D. E. Bonnell	
Lt. Dahlgren	

BOSTON P.O.E.

Col. Guy C. Rexroad	T. C.
Maj. Robert B. Gorman	M. C.
Capt. Alexander J. Young	M. C.

CONFERENCE, Port Surgeons and Troop Movement Officers, Cont'd.
12, 13, 14 October 1943.

SEATTLE P.O.E.

Col. Louis Brechemin	M. C.
Lt. Col. Anthony F. Stecher	G. S. C.
Maj. Emil S. Danishek	M. C.

LOS ANGELES P.O.E.

Lt. Col. J. L. Searles	
Lt. Col. Marcus D. White	M. C.
Maj. Sam G. Christian	
Capt. Fred B. Laughlin	

HAMPTON ROADS P.O.E.

Col. Thos. M. Lowry	M. C.
Lt. Col. Ernest H. Hawkwood	G. S. C.
Maj. Maynard C. Nicholl	G. S. C.
Maj. William A. Kenna	M. C.

NEW ORLEANS P.O.E.

Col. Robert F. Bradish
Lt. Col. Merrill W. Everhart
Maj. Albert J. Treigle

CHARLESTON P.O.E.

Lt. Col. Ernest M. Nielson	M. C.
Lt. Col. Richard D. Roquemore	T. C.
Maj. Otis F. Gay	M. C.

SECOND SERVICE COMMAND

Col. Charles M. Walson	M. C.

U. S. PUBLIC HEALTH SERVICE

Dr. R. E. Bodet - Senior Surgeon (Lt.Col.)
Dr. Robert Olesen - Chief Quarrentine Officer, New York Port.
Dr. Thomas Parran, Surgeon General (14th only)

WAR SHIPPING ADMINISTRATION

Dr. Justin K. Fuller - Medical Director (Col.)
U.S. Public Health Service (13th only)
Comdr. W. G. Terwilleger, U.S.N.R.- Deputy Medical Director

SURGEON GENERAL'S OFFICE (To attend a part of Conference only)

		DATE
Col. Stanhope Bayne-Jones	M. C.	13
Col. William A. Hardenbergh	Sn. C.	13
Lt. Col. Anthony J. Lanza	M. C.	13 & 14
Lt. Col. Karl R. Lundeberg	M. C.	13
Lt. Col. Arnold L. Ahnfeldt	M. C.	13
Lt. Col. Thomas B. Turner	M. C.	13
Maj. Lloyd K. Clark	Sn. C.	13
1st Lt. Franklin S. Blanton	Sn. C.	13
Mr. Randall Latta - Civilian Employee, Bureau of Entomology U.S.Dept.of Agriculture.		13

NEW YORK P.O.E. (To attend a part of Conference only)

Maj. Gen. Homer M. Groninger U.S.A. Opening Session

CONFERENCE OF PORT SURGEONS AND TROOP MOVEMENTS OFFICERS
Fort Hamilton, 12-14 October 1943

AGENDA

Tuesday, 12 October 1943

0900-0915	Welcoming address	Major General Homer M. Groninger, Commanding General, N.Y.P.E.
0915-0945	Introductory address	Brigadier General Robert H. Wylie, Acting Chief of Transportation
0945-1015	Orientation discussion of outbound movements as related to personnel, with special emphasis on those phases of outbound movements of interest to Port Surgeons	Lt. Colonel Donald E. Farr, TC, Chief Overseas Troops Branch, Movements Division, Office of the Chief of Transportation
1015-1030	Break	
1030-1100	Orientation discussion of inbound movements of personnel, with special reference to over-all view as seen at Office of the Chief of Transportation	Major Jerry A. Griffin, Chief, Debarkation Section, Movements Division, Office of the Chief of Transportation
1100-1130	Troop movements through ports	Colonel George E. Fingarson, Director, Troop Movements Division, N.Y.P.E.
1130-1200	Open period for general discussion and questions reference subjects presented during morning	
1200-1330	Lunch	
1330-1930	Inspection of certain port installations and of a transport	

ALL TIMES SHOWN AFTER 1330 ARE APPROXIMATE

1330	Depart Fort Hamilton by boat	
1400	Inspect Staten Island Terminal Disinfestation Plant	Colonel Harry R. Melton, Port Surgeon, N.Y.P.E.
1530	Inspect Disinfestation Plant at Piers 83 and 84	Colonel Harry R. Melton, Port Surgeon, N.Y.P.E.

1930	Depart for Fort Hamilton	

Wednesday, 13 October 1943

0900-0945	Medical Responsibilities of The Chief of Transportation	Colonel A. H. Schwichtenberg, MC, Chief, Hospital Administration Division, Surgeon General's Office; and Lt. Colonel Donald E. Farr, TC, Chief, Overseas Troop Branch, Movements Division, Office of the Chief of Transportation.
0945-1045	Medical Transport Regulations; Instructions to Transport Surgeons	Lt. Colonel George M. Schuhmann, MC, Asst. Port Surgeon, N.Y.P.E.
1045-1100	Break	
1100-1200	Sea evacuation operations	Lt. Colonel John C. Fitzpatrick, MC, Liaison to Office of the Chief of Transportation
1200-1330	Lunch	
1330-1400	Prevention of air-borne disease on transports	Colonel Stanhope Bayne-Jones, MC, Asst. Director, Preventive Medicine Division, Surgeon General's Office
1400-1430	Venereal disease problems in staging areas and on transports.	Lt. Colonel Thomas B. Turner, MC, Chief, Venereal Disease Control Branch, Preventive Medicine Division, Surgeon General's Office.

1430-1515	Water Purification as related to ships transporting troops	Captain Daniel E. Bonnell, SC, Asst. to Port Surgeon, S.F.P.E. and Colonel William A. Hardenbergh, SC, Chief, Sanitary Engineers Branch, Preventive Medicine Division, Surgeon General's Office.
1515-1545	Army industrial medical program as related to ports of embarkation	Lt. Colonel Anthony B. Lanza, MC, Chief, Occupational Hygienne Branch, Preventive Medicine Division, Surgeon General's Office.
1545-1600	Break	
1600-1715	a. Status of methyl bromide facilities at present for the delousing at ports	1st Lt. Franklin S. Blanton, SC, Asst. Sanitation Branch, Preventive Medicine Division, Surgeon General's Office.
	b. Discussion of the general problem of the importation of disease by returning troops	Lt. Colonel Karl R. Lundeberg, Chief, Epidemiology Branch, Preventive Medicine Division, Surgeon General's Office
1715-1800	Open period for discussion of foregoing problems	

Thursday, 14 October 1943

0900-1200	Open period	
	Discussion of prevention of entry of communicable diseases into the United States by coordination of agencies involved	Dr. Robert Olesen, Medical Director, U. S. Public Health Service, Chief, Quarantine Office, Port of New York.
	Remainder of period will be available for discussion of previous problems, presentation of specific questions by Port Representatives, etc.	

BRIG. GENERAL WYLIE:

I ask you to take your seats. The Transportation Corps and its rather far flung activities has become of age over night. A year and a half ago we were struggling with a tremendous task. We were merely trying to move men and materials some place, somewhere, with the most inadequate facilities and with very little organization. We have begun to refine our activities somewhat now. We had a Port Commander's conference at Boston sometime ago. At that time the Port Commanders and officers from the Chief of Transportation were able to get together and discuss our mutual problems. We found it most helpful. We followed that with a Zone of Transportation conference, and we found it was extremely beneficial in improving that organization. The duties of the Port Surgeons are such that we feel it essential to get together where we can discuss various responsibilities of medicine and of transportation in dealing with this huge problem of moving men. General Groninger has very kindly made this facility available for holding this conference. It requires a great deal of preparation and a great deal of work, and we are truly appreciative of the fact that he has done this. I might state that in 1940, sometime in September, the Chief of Staff was concerned about our Ports of Embarkation. We had two primary ports. They were getting on their way slowly, and they selected from the Army at large, two officers who had spunk, drive, and experience to get the things done. One of those officers has since left and gone to a position of considerable importance overseas. The other one who had a big Port and a big job is still in here pitching. It is a pleasure to introduce to you Major General Groninger, Commanding General, New York Port of Embarkation.

MAJOR GENERAL GRONINGER:

We welcome you to the New York Port of Embarkation. We work hard and we make mistakes. I hope your conference brings out some of the mistakes that we have made. I made mistakes in the selection of personnel. It seems that my job primarily is to find out what ought to be done and then to get the right man to do it. Now that is a problem, to get the right man to do the job, even with this small crew. On these transports we have got to have good men. That includes the Transport Commanders and the Surgeons, especially. I was just telling General Wylie at breakfact, "Of course, we have got to put on those men that we have with us, but I think we can get tougher men." I think we can do the job. I think the importance of it is such that if they are not good, we must not hesitate; we have got to move. Now in the last week or two, we have had difficulties on our ships, all about the same thing--diarrhea. Then the reports came in. I would just like to read about two sentences of one report. The reports are all the same with conclusions and recommendations. Of course we people who are here at the Port are posed with a problem, to which we have to give some consideration. He goes

on here to conclusions, "This is because of unsanitary conditions in the galley." That is what I get right along--"Unsanitary conditions in the galley." "Principal contributary cause, over loading." I know people say that isn't so. Well, I can go on here. No use reading more. I will summarize it for you. He comes out with overloading. That is one problem.

Ill-disciplined units, that is two. I mean, poorly disciplined units on board, especially the officers. There is no under-estimate of that, a little twang of seasickness or something like that. I don't think an officer should get seasick. I have gone out as Senior Commander of Troops four times and I have been performing police officer's business on about eight voyages, and I don't believe there is any excuse for it. Oh, there might be one or two who can't walk. They may be sick, you fellows know more about that; but I think there is a good deal of bunk in seasickness with officers. I don't think they should get seasick. Certainly they should not get sick enough that they cannot walk and go down to do their job. I think that is one of our principal contributory causes. Overloading was, yes, but that is over now for awhile. I think that poorly disciplined officers is another. Out of the last two or three shifts, it happened to be bunches of casuals going over from Hampton Roads on a ship sent down from here. They were good ships, too. Well, we fixed up a crew according to our charts, etc., I mean the staff, but when they got down to Hampton Roads, they shoved on board a lot of colored soldiers, colored detachments and all that stuff, and they had no medical officers with them so that the poor Transport Surgeon had no one to help him. There he was all by himself. Then the same old story-they ran out of medicine--that is in every report. That is queer business. I know you are going to say how much medicine should they have? I don't know. But they have to have a lot. It is grim business. Coming back once I had a boat load of 2,100 wounded bed cases strapped to their bunks and we got in a storm, and we lost one hundred miles in three days of travel. We had to push meals over the floor on hands and knees, and I have a great deal of sympathy for those who were in charge of that. I have been through it now several times and we have got to get good officers for that, so lets think about that in the preparation of this work. I know we could write about regulations here and of all this, down from old George Washington himself, somewhere, but this Transport Commander is the boss on the ship and when you get this good enough, lets have it sort of fit in through the usual channel. While we are doing that it might be a good plan. I don't know any authority who knows these regulations. I assume it isn't in the book. Maybe it could be put in the book. We have been doing it right along.

It would be a good thing to put it in. That would be a little more power to make these people do what we want.

Now if I can give any help here in this, any time in a discussion, if I could be of help to you, I will come up here. I know a lot of you have had more experience than I. I want to make you feel you can come here. I will do everything I can to further this conference, which I feel is bound to result in good. Any questions you would like me to answer now? (No answer from the floor) Thanks very much.

BRIG. GENERAL WYLIE:

Before we go further I should like to ask the Commanding Officer of Fort Hamilton to give you some ground rules.

COLONEL MAAS:

Good morning, gentlemen. Could I have about four minutes?

Answer: You could have four and a half-as much as you want.

COLONEL MAAS:

Thank you. Will you gentlemen believe it - you might become lost on this post. Folks do. So will you please take this out of your envelope. (Audience takes papers out of envelopes)

There is no north nor south on this map. Place the Officers Club next to you, the end of it to you, with headquarters away from you. North is from the lower right hand corner to the upper left hand corner. That's north. You can see the Officers Club is near you and you go directly up this road (pointing) right up in this direction 'til you come to the gate. Then you go up to the first car line and turn to the right for the subway. If you can just place this in your mind, get this in your mind, then you won't become lost. And then those of you who live in 600 and 249 can see where your building is right from here. Your map will be pretty nearly oriented.

I would like to say a word about the meals at this club. Of course you all have a membership card. The portions served are not too large, but don't be embarrassed if you feel you want something more to eat. Don't be embarrassed to ask for another helping. We have had to cut the helpings in order to prevent waste. We have had a hard time getting our ration points. However, please don't fail to ask for more here, at the meals, if you desire it.

Now we haven't provided any entertainment here at the post, because I believe that there is a better place in New York for entertainment, and you will find a list of activities in New York on another sheet that you have. And I want you to feel free-don't try to remember telephone numbers - to call the Commanding Officer, Executive Officer or any Adjutant in case you want something, anything. And Lieut. Dowdy at the desk down there will be

on duty 24 hours a day. He will leave a number where he or one of his representatives will be able to answer anything or any question you might ask within reason. You will find out here that we are unable to supply Government cars for you. However, transportation - the civilian organization here has the cars, and by seeing Lt. Dowdy, you will be able to get transportation. Thank you very much.

COLONEL MELTON:

May I suggest to you to make some remarks about the 7th Avenue entrance. I see some of them came in by taxicabs. Can they come in there, or do you expect them all to come in the main gate?

COLONEL MAAS:

There is a 7th Avenue gate. If you come in taxicabs, the driver will say "The main gate or the 7th Avenue gate?" I suggest you use the main gate. However, if he does take the 7th Avenue gate - that is near to 249, where many of you live - just use that gate, that's all. Nothing wrong about that. They can come in any gate they want. Just say the main gate. It doesn't cost any more. More pleasant driving in anyway.

BRIG. GENERAL WYLIE:

In order that everyone here may know everyone else, I am going to ask that each officer in turn stand up, announce his name, his job, and his station. I will start it off, and then ask the officer sitting here, and then go around these tables to the left, and then around (pointing).

I am General Wylie, acting Chief of Transportation from Washington.

LT COLONEL FITZPATRICK, is our officer from the Surgeon General's Office, who is in the office of the Chief of Transportation.

LT COLONEL FARR, Overseas Troop Movement, Chief of Transportation.

COLONEL SCHWICHTENBERG, Chief of the Hospital Administration, of the Surgeon General's Office.

MAJOR SCHEREMETA, Assistant to the Port Surgeon, NYPE.

COLONEL FINGARSON, Troop Movement Officer of New York Port.

COLONEL MELTON, Port Surgeon, New York Port.

LT COLONEL SCHUHMANN, Assistant Port Surgeon, New York Port.

MAJOR GORMAN, Surgeon, Boston Port.

COLONEL REXROAD, In Charge of Troop Control Division, Boston Port.

CAPTAIN ALEXANDER J. YOUNG, Executive Officer, Boston Port.

COLONEL LOWRY, Port Surgeon, Hampton Roads Port.

MAJOR KENNA, Hampton Roads Port.

MAJOR NICHOLL, In Charge of Operations, Hampton Roads Port.

MAJOR GAY, Executive Officer, Charleston Port.

LT. COLONEL ROQUEMORE, Troop Movement, Charleston Port

LT. COLONEL NIELSON, Port Surgeon, Charleston Port.

COLONEL HEISKELL, Assistant Chief, Office of the Chief of Transportation.

MAJOR AXELROD, Port Supply, New York Port.

SENIOR SURGEON BODET, Lt. Colonel Bodet, U.S. Public Health Service, Washington.

COMMANDER TERWILLEGER, U.S.N.R., Deputy Medical Director, Division of Operations, War Shipping Administration.

LT. COLONEL PADAN, Surgeon General's Office.

LT. COLONEL BRANSTATER, Officer in Charge, Officers Transport Detachment, New York Port

LT. COLONEL FEISTEL, Officer in Charge of Operation, Water Division, New York Port.

MAJOR GRIFFIN, Office of the Chief of Transportation.

CAPTAIN BONNELL, San Francisco Port.

COLONEL CRAIG, Director of Operations, San Francisco Port.

BRIGADIER GENERAL DE WITT, Port Surgeon, San Francisco Port.

MAJOR QUINN, Assistant Port Surgeon, San Francisco Port.

LT. DAHLGREN, Assistant Executive Officer, Port Surgeon's Office, San Francisco Port.

LT. COLONEL STECHER, Chief of Operations, Seattle Port.

COLONEL BRECHEMIN, Port Surgeon, Seattle Port.

COLONEL BOYLE, Awaiting assignment at Seattle Port.

MAJOR DANISHEK, Assistant Port Surgeon, Seattle Port.

COLONEL WALSON, Second Service Command.

CAPTAIN LAUGHLIN, Water Division, Los Angeles Port.

LT. COLONEL SEARLES, Director of Operation, Los Angeles Port.

LT. COLONEL WHITE, Port Surgeon, Los Angeles Port.

MAJOR CHRISTIAN, Executive Officer, Los Angeles Port.

MAJOR TREIGLE, Troop Movement Officer, New Orleans Port.

COLONEL BRADISH, Port Surgeon, New Orleans Port.

LT. COLONEL EVERHART, Executive Port Surgeon, New Orleans Port.

LT. COLONEL DORSKI, Director of Administration, New York Port.

MAJOR BUSH, Port Surgeon Office, New York Port.

BRIGADIER GENERAL WYLIE:

You might understand, gentlemen, that's one way I get my time taken up on the platform -- it saves wear and tear on your nerves, and it saves words from me. I want to announce two or three ground rules so far as the conduct of the conference is concerned. First of all I wish to apologize for being unable to stay with you throughout the conference. As it happens, a good many of our officers from Washington are away, and I am, after a fashion, attempting to do two or three jobs and it makes some demands on my time, which will not permit my remaining here. I would like to stay here, not that I think I can contribute a great deal to the conference, but in order that I might learn a little something about your problems -- for only by knowing these problems may we be in a position to take the necessary action -- insofar as it is within our province -- to help you solve these problems.

I recall that not more than three or four years ago at one of our primary ports, Port Surgeon was a part-time job. The officer who held that job was Station Surgeon at a rather large post, and he "doubled in brass" by coming down to the Port and boarding transports when they arrived. Now when I see this assembly of distinguished Medical Officers -- and we have been most fortunate in the calibre of officers that the Surgeon General has made available to our Ports -- I realize that we are dealing with something quite large in comparison with that small-time operation.

There is no question but what you each have problems, suggestions, ideas, and undoubtedly criticisms, not only of some of the operations in the field, but of orders and regulations that are issued in Washington. In your discussions here, I ask that you be frank, very frank. I ask also, because of the time element, that you be brief. If you have a gripe, give it to us, but be specific; and if you are specific, you will be brief. However, I think we must remember to keep a sense of balance.

I am just reminded of a story that I told to some Transportation Officers the other day in illustrating that same point. I believe the drift of it was--The General received a telegram stating that one section of his Army had been surrounded and they had lost three Brig Generals and one hundred mules, and he said "By God our mules are expensive". So keep a sense of value. Remember to be brief, and above all, if this conference is to mean anything to you at all, and anything to us, be frank. If the things we do in the office of the Chief are objectionable, say so. We don't guarantee to agree with you and accept your criticism without some protest. We may have arguments of our own and ask our own officers to do the same thing. And I feel sure that I speak for the Surgeon General when I say that he, too, welcomes criticism.

I had an opportunity to go up to Chicago with him last Wednesday and we discussed this conference; and at that time he expressed his regret at being unable to be present. However, I believe his office is well represented here.

General Groninger was discussing some of the difficulties of Transport Commanders and Transport Surgeons. I thought he was going to read a part of a letter which we received in our office just recently. It was addressed to General Gross personally and says, "Dear Charlie: I am enclosing this 'jewel' for your amusement. It is a copy of a memorandum sent by a Transport Commander to a Transport Surgeon. It is a history of a ship that arrived with a real epidemic of diarrhea, which involved some three thousand out of six thousand colored troops. The Transport Surgeon had been making sanitary reports which apparently irritated the Transport Commander and provoked this jam. I am most sympathetic with the poor Transport Commander and his aversion to bails of paper, but really, Charlie, I am surprised at you for sponsoring the idea that three thousand cases of diarrhea is a minor matter. I remember your concern over one dirty kitchen that we saw; so, my lad, here's to our Transportation Corps to take the broader outlook and save paper". He incloses the memorandum which was written by the Transport Commander to his Transport Surgeon. Apparently, the Transport Surgeon had felt it necessary to write a number of memoranda to ships' officers and others, and these memoranda were quite critical and they were so written that the doctor might have it in the record because he thought it would produce results, I don't know. But the Transport Commander took exception and wrote to

the Surgeon: "This type of paper work is disapproved. All inter-office notifications can be by conversation. These memos are often misunderstood and cause annoyances between ships' and military personnel. We are all working for one purpose - the transportation of troops safely and in good health. There is no necessity for anyone of us to go on record as to any faults or difficiences of other heads as we are not without fault ourselves. Instead of wasting time in writing, it can be better used in supervision. We, that is, the Transport Officer, and the Medical Officer, are not numerous enough to supervise sixty-five hundred men of this breed and we must rely on their officers. The troops officers are neither experienced nor capable of handling their men. That is the basic trouble, and we brought them down so far without riot or serious trouble. Whether or not our mess table is perfectly white is a minor matter in comparison. The sickness and its present extent is a minor matter. It is my advice to take a broader outlook and try to get at the particular trouble, not at everyone else's, and then have a talk with the personnel. Save the paper, you may need it also."

I hope that does not of necessity represent ideas of all Transport Commanders dealing with surgeons who are trying to cope with an epidemic at sea, but I must agree with him to this extent, that we often write far too many memoranda. We often feel it necessary to get ourselves on record so that when something is being investigated-the next year or the next month-you can prove that it was the other fellow's fault. I have some notes that were prepared, and although I find that I have already used up a good deal of my time, I would like to cover just a portion of these, as far as the Transportation Corps is concerned with the movement of both men and material. Insofar as our discussions here are concerned, we should consider the movement of men, because the common tasks between the Surgeon General and the Chief of Transportation is primarily the movement of men. The techniques involved in the two branches have little in common. The daily activities of the Surgeon and the Transportation Officer are quite different, but, there are great basic things which we share in common. In a very little way, both the Medical Corps and the Transportation Corps serve in a guardianship capacity for the rest of the Army. Medical Corps responsibility is everlasting. It goes on from the time a man is first inducted until he is discharged or reaches the grade. In the case of the Transportation Corps, our responsibility is somewhat sporadic. We move them by rail or by highway carrier. We then bring them into a Staging Area where we accept command responsibility. Then from the Staging Area they go aboard ship and it is our responsibility to get them to their destination safely and in good health. We may state that transportation is most important in this war effort. We cannot say that by our means of transportation, the war can be won but we can state definitely without adequate transportation, the war can be lost. By the same token,

no one can say that the Medical Corps could of itself win the war. But if the Medical Corps fails to maintain the health of the Army, they will definitely contribute to defeat. Jointly, we must 'face the music' or take the credit. Jointly, therefore, it behooves us to talk of our problems. We can touch only upon the principle of these problems for the individual problems are almost infinite in operations of this scope that we are carrying on.

In the fiscal year 1943, we jointly safeguarded the well-being of ********** passengers going to oversea destinations and we shared the headaches of *** troop ships, not counting cargo vessels which carry troops. During the fiscal year, we saw the average burden increase ***% and taking the last month in comparison with the first, we saw Staging Area capacity rise from ******* to ******* and most of us recall that just a very few years ago, the total strength of the Army was *******. We have seen the volume of troops overseas go up and up, and that meant for us an increase of 100% in the burden of moving cargo. For the Medical Corps, this must have meant a tremendous increase in problems for our men coming into action with all that it implies from a medical standpoint. For both of us that last fact brought tasks relating to the evacuation of the wounded, the transportation and disinfestation of prisoners and a host of other problems. I mention all this merely to say that the variety of problems we have experienced interest you as a prelude as to what is to come as to the volume and scope of operations in both of our establishments. We will continue to encounter problems we never dreamed of before. Both the Medical Corps and the Transportation Corps will face the challenge of circumstances that seem beyond our power to cope with. Over and over again we will find ourselves in situations that press with an infinite number of reasons by which to excuse ourselves for the non-performance of the things we are charged to perform. It will be up to us to remember that a war is not won by men who find perfectly valid reasons for not doing something. Rather, they are won by men who seek out the one possible way to do what seemed impossible. They are not won by prudence but by "fighting will" above all. We must remember that men must be moved. We may take the utmost precaution in health and security. We must stop at length to insure their being and safety, those things are indispensable. Yet they are also secondary. We must at best compromise with circumstances. There is no time for "pressurism". By keeping in mind the primary purpose of our actions, by keeping an appreciation in mind of our respective responsibilities, we can wipe out our mutual problems.

That brings us to the matter of technical, as against command channels. I imagine that some officers will discuss some phases of this question, but this problem of channels is difficult in

the Army and in war time, because we have two types of officers; those who are normally civilians and are now serving in the military service, and those who are old soldiers accustomed to the ways of the peace-time army. The peace time civilian who finds himself in the uniform often finds it hard to get used to the authority which characterizes the Army, and the old soldier finds it hard to get out of the rut of habits formed in the Army when the scope and urgency of command were only a fraction as great as they are now in war time. Your experience will tell you what I mean by command and technical responsibility. There are many details which are purely technical. Occasionally, something that appears to be a technical matter, however, at the outset, becomes a command function. When you discuss the policy of evacuation of patients from overseas, you must assume that primarily it is a technical medical matter, but you realize that the whole conduct of the war has been placed by the ability of ships to move men and materials. You realize that the command side of that question is a most important one. If ships are tied up to move convalescents, to evacuate patients, they are not carrying fighting troops to the front, so that the commander in the field and those on the general staff charged with the strategy have a very real interest in this problem of evacuation and in determining what the policy may be. I would like to reiterate one thing I covered there, that is, you have a job to do. We have always a conflict between the necessity for action, speedy action, safety and security. Certain calculated risks must be taken. We have the responsibilities of the public health service. We have the responsibilities of the Medical Corps. We have the steamboat inspection service, the various laws and rules covering navigation; the various responsibilities regarding safety of life at sea. We could, if we were so minded, find sufficient reason to practically stop our operation. However, our record has been one, I believe, of accomplishment. We have been able to move far more troops and far more material than was ever contemplated with the limited facilities available. It is only by facing our problems squarely with the intent to do, and do our utmost, that we may hope to contribute our part to a speedy victory. Now as regards the conduct of this conference, I should like to ask that those officers who are presenting a paper or a subject come to the platform. I believe that you can hear better from up here. Am I correct?

FROM THE FLOOR: Yes, Sir.

BRIGADIER GENERAL WYLIE:

And there is also a tendency on the part of some of us if we get down on the floor, we walk back and forth, and engage in a lot of unnecessary "bull". We haven't time for that as much as it may be appreciated. I am going to ask that

those officers who have subjects to present come to the platform. If following any talk, you have questions, you will have a chance to present them. I don't propose that these questions will be answered in full at that time. It may require some research or cooperation with others. But ask the questions so that they may be made of record, and if they cannot be answered immediately, they will be taken care of at the latter part of the conference.

As I told you, one of our most important jobs is the movement of troops, and it happens that we have an officer here who has spent a great deal of time in the last three years doing just that thing. He started the job long before Pearl Harbor in G-4, and although he has had a variety of titles since, he still is the one officer in Washington who puts his weight behind the movement of troops and gets them out, in spite of shortages of transports and red-tape--Lt. Colonel D. F. Farr.

LT COLONEL FARR:

General Wylie and gentlemen. The General refused to let me introduce him when he came up on the platform. I admit that probably he doesn't need any introduction, because I suspect that nearly everyone here knows him. It is just possible that there are some who have not come in contact with him before. It might be of interest to know that General Wylie came to the Transportation Corps shortly after Pearl Harbor, after a very careful survey had been made in the field of which officers could come in who knew something about the Transportation business. General Wylie was selected by General Gross because of the fact that he knew more about how to handle transports, people on transports, ports of embarkation and their accompanying work, than anyone else he could place his hands on, so General Wylie became a part of the Corps and I think he will probably stay part of the Corps for a long time.

This conference is a very fine opportunity to meet many of you gentlemen to whom I have talked in the past two years and from whom I received lots of letters but have never had the opportunity to meet. I think it will be an opportunity for all of you to get together on some of these problems, also. Now, the part that I have at this time is largely an orientation and background of many of the things which happen in Washington that make you do some of the things which sound rather peculiar at times, but there is, in many instances at least, a fairly good background for them. At the beginning of the War, as many of you remember, the problem of troop movements was quite simple. Somebody in the General Staff would call up a unit at its home station and say, "Three days from now", or maybe five--if they were generous, "you will be ready to leave--go to the San Francisco Port of Embarkation for overseas duty". In the meantime, G-3 was writing a very nice detailed order on a few of the things they were to take with them. Training status didn't particularly

bother anybody. Equipment was, of course, of some importance, but not too much. The units arrived in the staging areas with very little preparation in many cases. Our ports rose to the occasion admirably. They went through final type physical examinations in many cases. The matter of equipping was taken care of, and even in those early days our troops went out very well equipped and in as good health as could be expected, considering the amount of time that was available to take care of them. But immediately we all became aware of the fact that we must do something a little sounder than that in order to get troops overseas in good fighting trim and in large quantities. New regulations were written by the General Staff to cover these things. Nobody paid any attention to the peace-time regulations then in effect anyway, so there might as well be some new ones. New training requirements were established and the problem of equipping was given a great deal of thought. This evolution continued to take place for quite some little time and at the present time we are now in such a position that if personnel arriving in the port areas do not come as they are supposed to, we have the right to send them back to the last station from which they came and let them fix them up there. This is the proper set-up after all for a port of embarkation. We should not find it necessary to be the inspector, to do the complete job. We have no place to put these people when we reject them. We must send them back to some other place in any event; therefore, they should never come in unless they are properly equipped or properly examined.

Now troop movements have changed in complex somewhat from those days when we very hurriedly called up an A.A.F. outfit in Tennessee and told it to move to San Francisco in a hurry, and officially we are now tied up in a great deal of red-tape. The way it starts is, the overseas commander puts in what is known as a six months' list. He keeps the Operations Division of the War Department General Staff informed as to his requirements in the way of troop units six months in advance. He makes all kinds of changes in these things and is never apparently quite satisfied with what he sends in, but he keeps it fairly well up-to-date.

After the Overseas Commander does put in his requirements, the General Staff then has to take those requirements, work them over a little bit -- because troops are not always available of the types the Overseas Commander asks for -- and puts out the War Department's six months' list. Now the purposes of this list after it is published by the War Department are several, the principal one of which is that the requirements for the unit may be ready at the time the unit is scheduled to go overseas. Because now, in this list, each unit is nominated by designation to go overseas during a certain monthly period. Therefore, you have a target for the equipment people to shoot at; you have a target for the training people to shoot at, so that if they follow the

schedules that are set up, material comes off the production line and you will have your unit completely trained and completely equipped at the proper times so that it may be moved overseas. Now there are a few other things that enter into this six months' list that are not quite so simple as one would like to have them.

First, the requirement of the Overseas Commander. That starts the list. However, there is another thing which is quite important and that is the availability of transportation to move the personnel overseas that has been requested. There are other matters that occasionally come in; the Overseas Theater Commander frequently wants more than the ceiling that his garrison is authorized to take. That has to be given some consideration in the command echelon, of course. But in general, there is every effort made to give him what he needs.

Now then, in determining capabilities, we generally go back to one of the major conferences. They carry very peculiar names such as "Trident", "Quadrant" and, as General Wylie suggested, when they have their fifth conference we might call it the "Dionne". They nevertheless get together very, very high echelons and decide what the strategy of the War is. But very peculiarly that strategy always comes down to "How many can we move?". At the last conference they made their deployment of troops that were necessary strategically to win the war, turned that over to the gentlemen of the transports of the United Nations to figure out "can it be done?". The boys went into a deep conference and came out a couple of days later, maybe a day later or the next morning after an all-night session, having shuffled their boats all over the world, they found "Yes", they could approximately meet that, but in order to do it there were certain things that were quite essential.

We had long distance phone conversations with the conferees up there discussing the matter of overloading in the wintertime, carrying more troops on the large ships than we carried before. The use of these prisoner-of-war freighters for the movement of outbound troops, and the difficulties we encountered were discussed fully. It was pointed out that morale might not be too high in many of these cases. These matters were carefully considered at the Quadrant Conference, and when the final result came out regarding the employment of troops all over the world, it was decided that it was necessary to carry more troops on vessels than had been our custom in the past. The shipping people gave up rules that they had been going under the last three years on the safety of vessels, by that I mean the safety of vessels from enemy attacks. They had to give in somewhat on that. All the calculated risks on getting the proper number of personnel into the area at the right time to do the job that had to be done. Now after these high-level over-all policies of strategy and movements are decided, we come back to the more commonplace--and if

I may say so--a more practical part of the troop movement, that is the monthly or convoy priority list. The six months' list, as provided by the General Staff and the Overseas Commanders, covers many units that are not available. They are supposed to be available but for some reason they don't materialize, so each month, or prior to each convoy sailing, there is a revision of that list as to the availability of units and also on the needs of those units overseas in the priority in which they are needed. Again the overseas theater commander comes in and states, "I need the following units in the following priority". This list is made up by the General Staff, again being correlated with the availability and again with the possibilities of movement of vessels between ports in order to accomplish this. It is a refined version of the six months' list rather than any radical change from it. Now as the process has been going on, the day to day statements are made as to shipping capabilities. I think those of you who are working intimately with the vessels know what I mean when I speak of day to day changes in availability. We had a few vessels that got out and had to come back, so the thing changes very, very rapidly. During this period troops are placed under movement orders for the overseas destination. We now try to get these directives issued about 45 days ahead of the actual movement and avoid the red tape we formerly had. Based on these directives and priority lists, the job is turned over to the Port of Embarkation for execution, and our office in Washington merely serves as a servicing agency to iron out such difficulties as may arise due to faulty directives or due to the things that happen beyond anyone's control and unforeseen at the time the job was set up.

In the handling of troop movements, both inbound or outbound, we tried to make it a basic rule that the port of embarkation is the operating agency and does its own job. We merely attempt to set up the means for that job and to follow through with such assistance as may be necessary from the standpoint of operating difficulties that come up. Now basically that routine which is a fairly simple routine, covers the fundamental part of troop movements. Very simply, you have the six months' list, you have a priority list, and you have a troop movement order. Fundamentally, that is all there is to it. However, troop movements go farther than just the paper work and the directives. There are also innumerable obstacles in the way of discussion of these movements according to the papers that are written, for instance, units that don't meet the requirements. They get ready to move to the staging area and General McNair says, "No, they haven't completed their training". Sometimes we get them in the staging area and the Port Surgeon says, "No, they have scarlet fever", or there may be other things that come up. Occasionally our men develop stomach-aches before they get out.

There is always a large number of unforeseen things which happen that you can't even name until they do happen. Therefore, the movement of troops becomes a bit on the personalized side. The actual movement depends more on the cooperation of individuals concerned than it does on the paperwork involved. In our own port set-up we can say that the successful set-up we have had is based on the attitude of everyone concerned. I don't mean just the troop movement people; that covers not only the Water Division, but also the Port Surgeon's office, the Supply Office, Troop Movement Office, etc. The port has to act as a whole on the movement of troops, and we have the finest bit of team work when it comes to moving troops that can be imagined. We know that we are skating on very thin ice occasionally, and occasionally we are told in no uncertain terms what the thin ice we are skating on, is. But it is all part of a calculated risk of getting troops to the place they should be at the time they should be there. It is not our intention to lose any troops on their way overseas. They may be a little bit uncomfortable, may sneeze a little bit; if they don't do any more than that, they will get over there and in a few days be as good as new. Anyway, the amount of discomfort that they may have to go through is going to be very small in comparison to the discomfort they are going through after they get over there. Now obviously the movement of troops is not a simple, straight-forward job. It is one that involves the personalities of your overseas commanders. It involves strategic policies and the policies of implementation placed on us by higher echelons, and it is a problem whose accomplishment depends entirely on overall cooperation. Now are there any questions which you would like to ask?

FROM THE FLOOR: (No response)

BRIGADIER GENERAL WYLIE:

I presume in the absence of questions that Colonel Farr has covered the subject very, very completely.

COLONEL CRAIG:

I have one question. Would it be possible to get these priority lists to us a little bit sooner?

LT COLONEL FARR:

That is a very touchy point. It is not possible. We would like to get those lists out sooner. You have a particular problem there. I might say that San Francisco's problem is a little bit different from others in that we have a joint priority list for the San Francisco area. We have, I think, three committees that have to meet before the priority list comes out. We have the South Pacific Army, Southwest Pacific Army and the joint committees of the Army and Navy that have to get

together and decide on the priority list for the South and Southwest Pacific which is a joint list. That is one of the reasons that your list is slow. We are attempting to speed that up. Next month's list will not be any faster because this is the 12th and it is being finished today and will be in your hands Thursday morning -- I mean in the port's hands Thursday morning, which is the 14th, which is a little better than it has been. I think the last one you got was on the 20th. These priority lists are subject to change very rapidly due to the change in military situations and they are very difficult to get at. In your particular case we will get them out faster, I am sure, next month. We are picking up a little bit.

LT COLONEL SEARLES:

On the priority list for the Los Angeles Port of Embarkation, they come out with that list relatively late too, and we usually just get one list there. As a consequence, the distribution is generally delayed for a day or two. If we could get three copies, we could take care of the distribution.

LT COLONEL FARR:

You will get distribution.

LT COLONEL SEARLES:

One other point. At present, the equipment going through Los Angeles is shipped on freighters and takes about twice as long as on passenger vessels and the troops get over there without their equipment. Is anything being done about that? We could move the readiness dates up so that we can get the equipment over there with the troops.

LT COLONEL FARR:

We have a difficult situation in the matter of readiness for your particular area, which is India. The trip from Los Angeles to India by troop vessels is approximately six weeks. The trip by freighter is anywhere from ten to fourteen weeks. Now you have your choice of one of two evils. Either you take your equipment away from the unit a month before it leaves so that the unit and its equipment may assemble together on the other side, or you take it from the unit when it leaves and it gets over there a month or two months after the unit. You have your choice of those two. Our General Staff unfortunately can't make up its mind which it wants to do. Sometimes it does one and sometimes it does the other. I think we should ship the equipment first and we are making some headway in that direction.

BRIGADIER GENERAL WYLIE:

Any other questions? (Pause) I see we have no other questions. Thank you Colonel Farr. I see we are a little bit ahead of schedule.

We will recess until 10:25.

(The conference recessed at 10:15 and reconvened at 10:25)

BRIGADIER GENERAL WYLIE:

I would like to announce for all concerned that we are taking minutes of this meeting and we hope that the minutes of today's session will be available tomorrow morning. This may save you the trouble of taking notes. I would also like to announce now that since I am unable to stay here, Colonel Farr will take over the rather pleasant function of conducting the conference during the next two days. Also, prior to our break at noon I believe Colonel Fingarson would like to know definitely whether all of you will accompany him on the tour of inspection this afternoon. I would suggest that you all go. Our big problem here so far has been moving troops overseas, but some four or five months ago we first began to feel the effects of the returning troops, whether they were prisoners-of-war, patients, casuals, or what have you. In fact, the inbound troop movements now each month are **** to what our **** troop movements were a few months before Pearl Harbor. There are certain problems that are peculiar to the inbound troop movements. You might say it was directly in reverse of our outbound movements, but such is not always the case. It has been necessary to establish within the Office of the Chief of Transportation a section concerned primarily with that. The orientation discussion of inbound movements of personnel with special reference to overall view, as seen by the Office of the Chief of Transportation, will be given by Major J. A. Griffin.

MAJOR GRIFFIN:

General Wylie, Gentlemen, There is an old adage that all that goes up is bound to come down. That is applicable to our movement of troops. We have concerned ourselves almost 100% with sending out troops in the past year or 18 months, and we have progressed to where it isn't the problem it was in the past. We now are bringing back troops in sufficient numbers to create a problem. Let me give you a brief history or resume of the past year. A year ago troops were being returned under the old procedure, or under the procedure set up by the old regulations, and it was of no concern particularly. There has been a gradual increase in these numbers to show and indicate that there is a need at this

time for advanced planning to insure the safe return of these troops. January of this year we returned **** personnel. For the sake of this discussion, let us break them down into Army for duty, patients, prisoners-of-war, miscellaneous. **** Total; **** Army for duty; **** patients; **** prisoners-of-war; **** miscellaneous personnel. In September of this year we had **** Army for duty; **** patients, ***** prisoners of war, **** miscellaneous or a total for September of ****** .

In order that you may better understand what we are trying to do with returning troops or how they should be handled, let's take each group briefly. The Army for duty returned as units or organizations. Orders were issued by the War Department for their return. The Overseas Commander gives them the shipment assignment number. We follow them and provide the transportation for their return. The patients - the second group: This group has had more work done on it to set up a procedure than any of the others. You have your various directives, you require the Overseas Commander to report what he has on hand, and what he expects in order that you at the ports may advise all concerned to get the hospitals to which they are going, in readiness; prepare to receive them and provide the necessary transportation, whether it be hospital trains or ambulances.

The third group: prisoner-of-war. There is an interesting subject. January - *****, February *****, March *****, April *****, in May we hit the jackpot - ***** came in. That presented a problem that none of us knew a great deal about. We had to experiment, to set up an SOP - Standard Operating Procedure for handling this. *****, *****, and ***** received the experience; ********** ****** received a little experience on this particular problem. I believe we now have the prisoner-of-war procedure fairly well in hand. Each port receiving its first shipment of prisoners-of-war make a bad start or two, but then when they get going, things go off very nicely.

The Overseas Commander can and will in the near future have to provide us with a projection of what they expect to return, then we will be able to provide the transportation. That projection as I anticipate it, is for units, organizations, odds and ends such as - leave or furlough, OCS, Aviation Cadet - that, I think, is going to be our problem.

I do not minimize the return of patients. We are having converted hospital ships which will, of course, relieve the situation somewhat but will not cause transports or troop transports not to be used. You will continuously use them. Your troop transports will have to be used to return your patients if your patient accumulation is anywhere near what we anticipate. On prisoner-of-war, the Overseas Commander of the North-African Theater estimated some three weeks before the fall of Africa that we would get between ***** and ********

prisoners of war. In May, we brought back ***** and the figures continue to go up. The figure was much higher than his *****, therefore, you can see that there is no way to project or make plans as to the return of personnel when you don't know how much personnel will be returned. That will, in my opinion, be our main unknown factor.

Under miscellaneous personnel, you have your Navy, civilians, and Allied personnel. The Allied personnel is being moved from coast to coast or from port of entry to a port of departure. Most of our movements of Allied personnel have been *****. We are doing it under *****. Again the precision of ***** had to be worked up. There are many points that had to be experimented with in order to find out just how it was to be handled. You will note that the miscellaneous personnel for January was *****, September, *****; you can see that it stayed fairly constant. I will come back to that type of personnel a little later. Very recently, the War Department issued a directive or unnumbered circular for the return of rotation personnel. I can't give you all the fine points of it. However, I have studied it. Again we are going to have to experiment with the details. Each Overseas Commander is going to interpret that unnumbered circular differently. I have discussed it with Headquarters, ASF. Their idea is that the Overseas Commander will return that personnel which he considers have been there long enough, or that circumstances require a man have a change of scenery, and it is thought that such men will be included on the rotation groups, which, by the way, are called Reception Station Groups. Very likely, that will be shortened to RS Groups. No one seems to know or to be able to give us any figures as to how many of these groups will be returned. I think that this is going to be quite a problem, not only from a rail transportation point, but from a medical point of view. Whereas, when units went out, they came from stations within the United States where there was very good control over their health. Now they are returning from areas where the control was not as good as it was, or is, in the United States. The Port Surgeons are going to have a problem that will require the utmost in cooperation between your line officers at the port and your medical officers to prevent diseases coming in, and yet not staging this personnel to such an extent that you will retard outgoing movements.

I would like to point out to you that under this rotation policy which I am discussing, as in the handling of patients, Port Commanders were authorized not only direct communication between the Port Commanders and the Oversea Commanders, but you were directed to carry on direct communication to guarantee the evacuation of your patients. Likewise, under the rotation directed, you are also authorized direct communication because the Oversea Commanders are going to interpret the rotational policy differently. It is going to be up to the Chief's office to give you a directive on what we would like to have. It is then going to be up to you to

contact your Oversea Commander and educate him to report this in the manner in which you can best handle and receive these people when they arrive. I urge you to take advantage of those two paragraphs in the two respective directives of direct communication. I have found that the Overseas Commands are most willing to give you what you want. They may be a little late in giving you the information but they will come through for you. Upon arrival of the various groups into the ports the question of transportation immediately arises.

In the handling of prisoners of war we tried to load them from ship to train. That required the utmost coordination within the port. The prisoners' fingerprints had to be taken. Then the trains had to be arranged and the troops turned over to the Service Command and moved out. A convoy with ***** to ***** prisoners-of-war arriving at the same time is no little problem. The ports concerned have done a swelljjob. We made a few mistakes, yes, but all in all we are quite pleased with the efficient manner in which the job was handled. The returns of organization groups, miscellaneous personnel, some of which have to have the detailed processing of granting furloughs, issuing service records - the furlough had to be made out at the port; therefore, you necessarily have to stage those men. However, we are endeavoring in our reception staging groups to stage them no longer than is absolutely necessary to provide the rail facilities and move these people to their chosen destination.

We can now look a little to the future. There are some questions I can't answer, I can only guess. Let's present it this way. While we are able at this time due to convoy regulation, due to other circumstances, to use some of the ports much more than we use some of the other ports, I do not believe that it w ll remain true that the outbound movement of troops is over. Ships will be allowed to move not in convoy or not with escort. That means that we can use all of the ports. We know and you will agree that we are going to bring these people back much faster than we sent them out. There is a possibility of hostilities ceasing in one theater and continuing in another. What then will happen? Are we going to bring them back? Are we going to bring some of them back and move others to the active theater? If the war ends in both theaters simultaneously I think the problem will be even greater. Johnny Doughboy wants to come home when the war is over. He doesn't want to stay there and I believe every available ship will be used for his return. I think one of the main factors in returning troops after this war will be that it will have to be controlled.

LT COLONEL PADAN:

I would like to make a plea rather than ask a question. I think this is a good time to discuss patients. This may seem to be a selfish interest but on behalf of The Adjutant General, The Surgeon General, and all Chiefs of Arms and Services, some of the representatives of the port operation officers here, I would like to make an urgent request that when a patient is returned to a port of embarkation and subsequently admitted to a General Hospital for treatment, that The Adjutant General or the Chief of Staff concerned be provided with a copy of orders assigning the patient to a replacement pool and to whatever hospital he may later go. This has been a cause of much embarrassment from Washington. Someone calls up -- some Congressman or someone from the White House -- inquiring about some patient who was to come back for treatment. The Adjutant General doesn't know anything about it. The Surgeon General doesn't know. If it is at all possible that we in Washington could get a copy of those orders, it would be a wonderful thing, and would be the answer to many questions that frequently arise.

But it does provide that The Adjutant General and Chief of Branches of Service, be provided with accompanying orders. Some of the ports I know have been crowded, but if it were at all possible -- if we in Washington could get copies of these orders, it would be a wonderful thing, and would ease down the questions that frequently arise. Yesterday morning they called up about two patients that are now in Valley Forge General Hospital. The Third Service Command wants to discharge these people and have them come before a retirement board. We don't know, The Adjutant General didn't know, nobody in Washington knew, what the men were assigned to. All we know was that they were in this hospital, and the only way we could find out, was to call the hospital and ask them how they got there.

MAJOR GRIFFIN:

Colonel, that is contained in the regulations.

LT COLONEL PADAN:

I know that, but what I would like to say is that we get the orders.

MAJOR GRIFFIN:

We shall take the necessary action to remind them.

BRIGADIER GENERAL WYLIE:

Might I ask who issues those orders?

LT COL PADAN:

The Port Commander. He has that authority and he cuts them. Undoubtedly, I think, from my viewpoint it is this. I know the Ground Forces have the same troubles and all the rest of them. The orders are cut assigning the individual to a Replacement Pool and where the problem comes in is in the distribution. All they need to do is mail a copy to The Adjutant General and the Chiefs of Branches.

MAJOR GRIFFIN:

Are there any other questions?

COLONEL FINGARSON:

I don't see where the Port Commander is involved in cutting the orders -- they are sent to a General Hospital.

MAJOR GRIFFIN:

Colonel, your headquarters is at present or was until very recently.

COLONEL FINGARSON:

I mean when they are being assigned.

MAJOR GRIFFIN:

When they return you assign them.

COLONEL MELTON:

I am glad this subject has been brought up. The Port of New York in issuing orders, that is the Commanding Officer of the New York Port, has been writing orders, on every patient that we get back. Now I am sure that does not hold good in all the ports. We have done that because the orders that we get from overseas do not assign them directly to a General Hospital in the interior. A great many of them are written assigning them to the New York Port. So in order to cover this we have written orders on every patient, and your office (indicating to Lt. Col. Padan) gets a copy of it. Now that entails quite a lot of work and I think you will find that our Port here has reported not only by the number of patients by classification, but a copy of the order has

been sent when we assign them to either Halloran General Hospital or Brentwood.

LT COLONEL PADAN:

In most instances, orders may have been sent and we don't frequently get them and The Adjutant General doesn't either. We are very grateful for the ones we do get. The Port in Seattle -- Seattle has been very good at it. Of course with the large volume coming through your Port, it takes a long time for them to get down to Washington.

COLONEL C. M. WILSON:

May I say that recently we have been sending to the Surgeon General, a copy of the form 52 on every patient admitted to the general hospital here at this Port who enters Halloran General Hospital or Brentwood, and we send a copy to the Surgeon General's Office.

LT COLONEL PARR:

We have in the case of our inbound movement, come out with a new directive of which Major Griffin has spoken. That is, a model type order that will be written by the overseas base, so that all overseas bases will write the same type of an order on the return of sound personnel. That order moves into the Port and requires an indorsement only on the part of the ports stating that group arrived on such and such a date, at such and such a time, and is directed to move by rail to such and such an area. Would a similar type of directive to overseas commanders to get a uniform type of order on the returning sick be the answer to the problem so that the Ports could really put such an indorsement on it?

LT COLONEL PADAN:

That would satisfy our needs. I speak on this not particularly from the Surgeon General's point of view but also The Adjutant General and the other Chiefs of arms and services. The information is just not coming. A man can stay at the General Hospital three months and the first thing we know about him is when a relative calls up and we don't know what pool he is assigned to, and often the pool doesn't get the order. That type order you speak about, it seems to me, would work if the Overseas Commander would issue orders returning him and the Port Commander would indorse it, "Hereby assigned to blank General Hospital and blank Replacement Pool

LT. COLONEL FARR:

Is there any objection on the part of any of the ports to such a decision?

LT. COLONEL DORSKI:

Would that procedure work out on the way you are getting orders, on individuals rather than on groups?

LT. COLONEL FARR:

There is still no reason why the overseas base hospital can't write an order "The following patients are moved in...." Of course that brings up the problem if they split those patients up to more than one general hospital you've got to split your orders. There probably should be individual orders. It would be a uniform typed order, all of them coming in the same. As I understand it now, you get as many different types of orders as you have overseas hospitals involved. It would be an indorsement on these but it would be a form stamped on, except for the name of the hospital, and I believe that should simplify your problems. I would like your comments. If you want to bring it up at a later discussion you can make notes on it.

COLONEL MELTON:

May I say a word, Colonel Farr?

COLONEL FARR:

Yes, Sir.

COLONEL MELTON:

If you have a standard order written in all of the foreign ports that this patient is transferred to a general hospital in the interior, that is all right. But they don't all write them like that and that is the reason that we have written orders on everybody. Now your present regulations require that officers' orders must be written in the Port and assign the officer to a replacement pool, but that does not hold good for the enlisted men. That could be corrected. All officers have to have orders written on them in the ports and in this order they are assigned to a replacement pool that has been designated by your office.

BRIGADIER GENERAL WYLIE:

We will continue that after the next presentation. This business of troop movements through ports is a rather weighty one. I remember it used to be a very serious job when we had two transports leaving the Port on the same day. I also remember that only three years ago in New York they insisted to the Quartermaster General, that they must not send out two transports within a 7 day period. It took seven days to get the ship loaded and ready to sail. The maximum capacity of any transport in those days was the"*****", which carried the tremendous number of *******. Now in the Port of New York, without batting an eye, they can embark ***** to ***** troops and put ***** on one ship. I think that no small part of that efficiency of organization is due to the present head of the Troop Movement Division in NewYork - Colonel Fingarson, who will discuss troop movement through the Port.

COLONEL FINGARSON:

General Wylie, General DeWitt, brother officers. I would first like to add my own personal welcome to that offered by our Port Commander. I hope the conference is profitable and that you have a full measure of enjoyment from the meeting. I assure you, if there is anything that I as Troop Movement Officer can personally do, do not hesitate to call on me. As you know, conferences sort of worry one because they take so much time and all that. We have them down at the Port three times a week. The Port Commander gets together the heads of the Operating Agencies and from the very beginning many of us thought it was a pain in the neck -- a waste of time-- "I have got so many things to do." But they do bring to light the gripes, the problems, and they do establish the policies under which we work. I am sure this conference is going to result in many benefits.

It has been my privilege to be the Troop Movement Officer in this Port since June 1941, when I was transferrred from Fort Slocum, where I had been located for 4 years, and there, involved in the movement of troops during peacetime. It was then the Overseas Recruit Depot and I would bring the troops down there and put them on the "*****" once and on the "*********" the next two weeks. Prior to that I was over in Hawaii as Acting Adjutant General in Schofield Barracks and among other duties that of Casual Officer, which involved debarkation of transports; receiving the troops; taking them out to Schofield Barracks, and making the assignments. And 3 or 4 days later sending back those who had completed their foreign service. Prior to that I was in the infantry. I don't care to plead guilty to any charge that I am a doughboy gone wrong.

It has been a pleasure and it was intensely interesting to work especially here at the Port, from the time, as General Wylie indicated, when we were working at a single pier, Pier 2, B.A.B. And noting the expansion, until now, there are some *** piers and some *** or *** different terminals involved in the operating of the Port area, let alone the staging areas, which of course are part of the Port.

Initially, prior to Pearl Harbor, the movements consisted of small task forces, moving through the ******** bases. The problem then was to ship the accompanying equipment, all of it, and a considerable amount of maintenance equipment with the troops. The development has progressed until at the present time we are nowhere near what we might call the five and ten cent scale. But where troops are moving with the small amount of accompanying equipment, the housekeeping equipment, and their organizational equipment having been pre-shipped and stocked in the overseas theater, the movement of the troops does not involve the accompanying movement of their equipment.

The Troop Movement Division at the Port sets the responsibility for the planning and supervision of all movements through and to the Port of troops. We are generally organized into three branches; a small Administrative Branch, a Planning Branch, and an Operating Branch. Generally their functions are, for the Planning Branch, to make the plans for the movement of troops to our staging areas and to the Port Terminals for embarkation; with the Operating Branch to carry out those plans in a supervisory capacity. So far as outbound movements go, it commences upon the receipt of the War Department movement directives. That puts those troops on our books, whether they are specifically ordered to go through this Port or whether there may be an operation passing through this Port or some other Port. Those orders are distributed to all agencies within the Port which require that information in the handling of those units passing through the Port. All supply - all transportation agencies - our first action is to send to the agencies, predicated on the movement orders, a warning instruction or a warning notice together with which is included a copy of the embarkation regulations pertaining to this Port, which sets down certain administrative action that should be taken by the unit and home station commanders. The shipment covered by that particular movement order is assigned to the officer designated as Shipment Officer in the Planning Branch. He is responsible for the issuance of instructions for the drafting of instructions for the movement of the unit to the staging areas. He sets up for us the order in which we may bring those troops into the Port and the order in which we should ship them out of the Port. We cannot act on a movement order alone, otherwise we may have units sitting in our staging areas for a long period

of time. We must wait for this priority list. Following that, the wishes of the Overseas Commanders must be known. That comes to us from Colonel Farr's Office and indicates what ships and what troops the Overseas Commander desires to dispatch to his various ports. With the additional information then, of the vessels that have been assigned to a particular shipment and with a knowledge of the space available in our staging areas, we are able to go ahead and plan and bring the units in so that with respect to the embarkation and sailing, the units will be in our staging area a period of approximately *****.

Prior to the issuance of the instructions to the agency issuing the movement order, the unit in our staging area is considerably coordinated to be effective within the Port. When we have a large shipment coming up, our common practice is to take the list of units involved in that particular shipment, and confer with the Port Transportation Officer. Having determined the date and bracket during which we want those units to arrive at our staging area and having determined the Staging Area that each unit should go to, confer with him and let him work out the specific details as to the time of arrival. There is considerable saving to rail transportation if they are able to work their rail assignments so as to minimize the waste of transportation.

Included also, then, in our instructions to the agencies to issue the orders are our certain supply and equipment instructions. These are prepared at this Port by the Initial Troop Equipment Division. We also place reminders in our instructions on the subject of training requirements; that is, firing with the appropriate weapon to be completed before arrival at the Staging Areas; and reminders concerning secrecy. As I said before, we hope that the movement of troops into staging areas and out of them, will permit them to stay there for ***** days. During that period, there is a continuation, of course, of the medical processing.

In connection with the movement of replacements, casuals, and smaller two-letter shipments, we have developed at this Port a code of medical processing with respect to immunization which is specified in the movement order, which also goes through the staging area. In other words, we have four different code specifications: Code A involves the immunization against small pox, paratyphoid, and tetanus; and B includes in addition, typhus; A, B and C, in addition, typhus, and yellow fever; and A and C of course, the basic immunization plus yellow fever. This is done so as to obviate an offset spreading the code, translating the number into the geographical location, into too many hands. It is retained in the Troop Movement Division and passed on to the staging areas so that then, by a pre-arranged code, just that immunization is affected with any particular shipment.

So far as the four numbered shipments are concerned, the movement order itself, of course, indicates what the requirements are. With the troops on hand then, and the ships available, or known to become available for any particular shipment, the overseas theater commanders wishes having been transmitted to us, were able to go ahead with our planning for the actual embarkation. That begins with the issuance of a unit assignment to ships. A study of the ships' characteristics is important. Some ships have considerable first-class space, which is especially suitable for carrying certain types of units such as hospital units where you have a large number of nurses, and many of the ships' characteristics are taken into consideration before the units are assigned to that particular ship. The wishes of commanders of large units, that is divisions, are also taken into consideration. Considerable leeway is given to the division commander's wishes in dividing his unit among two, three or four ships during shipment. Medical personnel included in any particular shipment is as nearly as possible, equally divided among all ships. That is standard operating procedure with us, to try to have medical personnel dispersed on all ships. From the operating division, when a ship is set up to be included in a convoy, there is assigned a liaison officer who goes aboard the ship and works together with the Transport Commander, determines first, what troops can best be carried; secondly, the exact plan for billeting the troops aboard the ship, to include the order in which the troops would be brought to the ship for loading, so as to minimize confusion incidental to loading the ship. In this connection, it is our problem to work out the plans when overloading is involved. Overloading varies among all the ships being overloaded according to its characteristics. Such matters as deck space for off-sleeping relief, sanitary facilities, messing facilites, among all others, must be considered for a definite figure before overloading can be determined. In that connection, of course, most of the liaison must be had with the Water Division so that a sensible overloading figure can be arrived at. Also, we find here that the Port Surgeon is very definitely involved in the selection of the permanent medical personnel assigned to these transports.

We have here, aside from our own Army and Navy transports, a considerable number of ******* transports. Some of them come in for only the one voyage. We consider that it is just as important to assign a complete staff to a ship - a ***** ship that's in for a single voyage - as it is for those which have been on several runs, or on our own ship. In preparing - still speaking of ***** ships - for the actual embarkation, it has become a common practice here at this Port to have conferences with Mr. Borer of the ****** Ministry and the ship's staff and his own staff to perfect plans for the embarkation.

The plans for the actual embarkation - of course - plans for the movement, initially, are advanced details. The ship's senior officer together with his assistant, go over the mess details, guard details, gunner details with the loading officers. When I say loading officers, I mean those officers from the traveling troops that are brought in to assist in the embarkation. They might be called compartment officers as they are stationed in the compartments and actually assist in the filling of the compartments as the troops are brought down by the guards which of course are furnished by the ships. I got a little ahead of myself on that, but that does explain the necessity of bringing in loading officers ahead of time. Other details are determined by the executive officer or Transport Commander. In the case of ***** ships, that is determined at the conference to which I have just referred. Having prepared and published the units assigned to shipment, which is simply a statement as to what troops are going to be billetted on what ship, the Port notifies the Overseas Commander in a forecast cable of that particular information. The next step is that of preparing the actual transportation and embarkation movement order and table causing the troops to move from the Staging Areas to the various terminals in the Port of Embarkation.

It is, of course, predicated on the time and order in which it is desired to have the troops arrive at certain piers and at certain ships, and further at certain gangways. The mechanics of working such a schedule which in the past involved troop movements involving as many as we had at one time which was about ***** trains, and others from **** up to **** trains, requires considerable planning, in order that confusion at the pier and on the ship during loading, is minimized. So far as we have been quite fortunate not having any considerable delays, but the problems are quite severe. We can readily understand that when you appreciate the fact that troops are moved to several different terminals and from several different staging areas, the Port Transportation Officer, of course, enjoys the full responsibility of the movement. My Planning Branch sets up the order in which we would like to have the troops come. We know by now what transportation can do. Having our plan in hand, it is presented to the Port Transportation Officer who works the plan out in detail to match the requirements as nearly as possible. As the troops arrive at the pier, in the usual manner, the movement is by train from Camp Kilmer, or Camp Shanks to the Jersey Terminals, sent by ferry boat to the various terminals and piers, where the embarkation from the ferry-boat to the various terminals and piers, where the embarkation from the ferry-boat or the train is supervised and the units conducted to the specified gangways.

I imagine that all ports employ a Red Cross Service, and bands have recently been ordered. It adds considerably to the morale of the troops. I am certain that all troop movement officers in the ports are conversant with the procedure at the gangplank; the actual checking aboard by name of every individual; the prompt preparation of the passenger list to the extent of indicating the reason for the dropping off of men who have been unable to complete the shipment; the removal of service records for such men; all are a part of the gangplank procedure. Following the completion of the actual loading; that is, getting the men aboard ship and locating their compartments, there remains the closing out of the deal by computing and submitting a recapitulation of the shipment and preparation by the Reports Branch on the basis of that information of the sailing cable.

In connection with debarkation, this division enjoys the supervision and control of all debarkations; is responsible for the receipt of all information and the dissemination of all information pertaining to the arrival of ships; and is responsible for the planning and supervision of the actual debarkation. It means that this division must lay new plans with nearly all other agencies in the Port. In connection with the Water Division, concerning the berthing plan and the specific requirements for the emptying out of one ship as compared with the others, and so on. Further, it notifies the Immigration and Customs Officials so that the appropriate panels may be present if the incoming passengers require it.

Port Transportation is involved -- arrangements for the transportation of troops and casuals to the staging areas or to new stations, or in the case of prisoners-of-war -- in that connection, the Second Service Command works in close cooperation with our officers in acting on instructions from the Provost Marshal movement with the Port Transportation Officer.

In connection with debarkation, the Port Surgeon must be consulted concerning the patients. Our standard operating procedure at this Port delegated to the Surgeon the direct supervision of the debarkation of all patients, working in close liaison with the Second Service Command Surgeon who determines where the patients are to be sent.

Normally, they are sent to the Halloran General Hospital not far distant from our Staten Island Terminal. He makes specific arrangements for the transportation of the patients and exercises close supervision over the entire movement. Upon the arrival at the pier, the usual procedure is for the liaison officer to board the ship together with the representative of the Port Surgeon's office and others, and to acquaint the Transport Commander with the proposed scheme of debarkation. It is usually predicated on commencing the action within a given period of time after the

arrival of the ship or on the following day if that day has been designated as the date for the debarkation. During the debarkation, the Port Surgeon, of course, exercises technical supervision of the operation of disinfestation plans. He, at the time of the arrival of the ship, makes a survey of the health condition aboard and determines what disinfestation must be accomplished. It is our practice here to disinfest all prisoners-of-war and in some instances, the escort guard. Further than that, we have not been disinfesting incoming personnel.

Gentlemen, that is all that I have time for. I have covered the operation of this division in this Port very sketchily. Are there any questions? I know that what I have said is peculiar undoubtedly to this particular Port. There is considerable variance in the methods used at the various Ports on account of the organization and on account of the peculiarities of a particular Port.

LT COLONEL SEARLES:

Does the New York Port of Embarkation have a gangplank supply officer?

COLONEL FINGARSON:

Acting in what capacity?

LT COLONEL SEARLES:

Under War Department Circular 127, it is provided that a gangplank supply officer may be designated to furnish last minute shortages as they may appear at the gangplank.

COLONEL FINGARSON:

That is taken care of by representatives of the Initial Troop Equipment Division, a fifth operating agency at this Port. Representatives of the Division are habitually present at, or in the vicinity of, the gangplank and are in a position to take care of any orders coming up at the last minute.

BRIGADIER GENERAL WYLIE:

You gentlemen may feel that the Transportation Corps side of the picture has been "hogging" the scene so far, but our desire was to lay the ground work by having some orientation by the Troop Movement Division of our office and giving you the Troop Movement side of the port operation. As Colonel Fingarson stated, his statements are peculiar to New

York and we find some differences of operating procedures, some differences of organization in all the Ports. I may state, however, that there is a definite tendency for standardization of both organization and procedure. As rapidly as one Port works out some sound procedure, that information is passed on to the other ports, and so far without any compulsion, many of these procedures have been accepted. There is a very definite policy on the part of Headquarters, ASF to provide standard charts and standard organizations. We are trying within the Transportation Corps to effect that on a reasonable basis, without interrupting operations or without losing some worthwhile procedure just in the interest of uniformity or standardization. Before we start with the open discussions, I should like to read the schedule for this evening and that should not be recorded.

(General Wylie reads schedule)

I might add, the conference tomorrow and the next day will be predominantly on the medical side, although the gentlemen this morning have been discussing operation from the Troop Movement or Transportation Officers' side, the balance of the program is almost entirely medical. I want to call attention also to the fact that all of these detailed arrangements here, and it is quite a job to make such arrangements, have been handled by Lt. Colonel Dorski, who is Assistant Chief of the Administrative Division. I don't believe Colonel Dorski will be present at the succeeding conferences, but he certainly is entitled to a vote of thanks for the arrangements he has made.

During this morning's conference we have mentioned several phases of troop movements. We brought out one question which I don't believe was completely answered regarding the issuance of orders for returning patients. If my understanding is correct, there are existing adequate instructions to cover the issuance of such orders. The difficulty seems to that even if the orders are not issued at all Ports, or if they are issued, there is some delay or some failure in distribution. I would like to check with the several Ports and see what their procedure is. General DeWitt, do you issue such orders?

BRIGADIER GENERAL DEWITT: No, only in the case of officers from the Replacement Pool. No other orders are issued. They are taken directly from ship and transferred to a General Hospital.

BRIGADIER GENERAL WYLIE:

Do you know if those orders are copies of those sent to the Surgeon General?

BRIGADIER GENERAL DE WITT:

I do not know. Distribution is made from Port Headquarters.

BRIGADIER GENERAL WYLIE:

Do you know, Colonel, if you receive such orders from San Francisco?

BRIGADIER GENERAL DE WITT:

We receive such orders from all ports. I am sure the Adjutant General receives them the same way. We are faced with the embarrassing fact that we don't receive even a majority of all orders and we'd like to get them all.

BRIGADIER GENERAL WYLIE:

In fact we are embarrassed at the same thing. We can't get orders from our officers applying to enlisted men.

BRIGADIER GENERAL DE WITT:

Primarily, we are worried about officers. The enlisted men, of course, come up, but are usually traced. But if some Colonel or other high ranking officer comes back, everyone comes to the last place. Everyone doesn't know where he is. He was a patient and we don't know his whereabouts.

BRIGADIER GENERAL WYLIE:

Colonel Padan?

LT COLONEL PADAN:

They call us. The Surgeon General and The Adjutant General -- they usually make the rounds, and they don't know, either. Officers, primarily.

BRIGADIER GENERAL WYLIE:

Too bad these Generals cause so much trouble. Clemenceau said,"I think that the war was too important a function to be entrusted to Generals". How about Seattle?

COLONEL BRECHEMIN:

We issue the orders, they are taken from the hospitals, and the officer, in addition, to the Replacement Pool. At this time they are recovered when a big heavy load comes in.

BRIGADIER GENERAL WYLIE:

How about Los Angeles?

LT COLONEL WHITE:

We come under San Francisco and we render no reports except to San Francisco. Orders are issued on officers, not on enlisted men.

BRIGADIER GENERAL WYLIE:

You are on your own now.

LT COLONEL WHITE:

That's right.

BRIGADIER GENERAL WYLIE:

New Orleans?

COLONEL BRADISH:

Issue orders on officers. There are no orders on enlisted men. On all patients arriving, the list is furnished the Surgeon General of the source of the patient and the disposition of patient. If I am not mistaken there was a recent discussion to the effect that general hospitals would report to the Surgeon of the Port of the source, and receipt of all overseas patients. It seems to me too, it would take slight augementation of that report to indicate the Pool assigned, and not bother with the reports where additional recording functions.

BRIGIDIER GENERAL WYLIE:

I am going to ask Colonel Fitzpatrick to go into that.

COLONEL BRADISH:

Before I close, I want to say there appears to be some leak in our area, that is, in reference to the technique in reporting the cases that come in from overseas, by air, through airports of entry. I think that has been worked on and discussed - direct evacuation from General Hospitals, direct to the Commanding Officers of Airports of Entry. But we don't know in many instances when they come in, where they come from, and it is very difficult for us to keep proper bookkeeping and accounting on their presence overseas and in our area when we don't have that information.

BRIG GENERAL WYLIE:

Boston?

MAJOR GORMAN:

Boston issues orders on both enlisted men and officers.

BRIG GENERAL WYLIE:

Hampton Roads?

COLONEL LOWRY:

Since the start, we have issued orders on enlisted men and officers from the Commander. Copies of those orders go along with the report of the patients to the Surgeon General's Office and to the Office of the Chief of Transportation, and a copy of the records to The Adjutant General of the Army. Since the issuance of Section 82, in addition all officers are, on the same order, assigned to the nearest pool of their Service.

BRIG GENERAL WYLIE:

Charleston?

LT COLONEL NIELSON:

Charleston hasn't had a patient.

BRIG GENERAL WYLIE:

We tried to get you some, but nearly all stole off the ship. Any further on the orders, Colonel Melton?

COLONEL MELTON:

No, Sir. I think our orders are the same as Hampton Roads. As for the distribution of these orders, that's up to the personnel. If we sent them out from our office, as Hampton Roads, it seems to me that personnel is responsible.

BRIGADIER GENERAL WYLIE:

I agree with you completely.

LT COLONEL RADAN:

I am reasonably sure that what we put on the record is complete.

LT COLONEL DORSKI:

From our Port, our orders are sent to the Surgeon General and also to the Chief of Transportation. There is a possibility they get to your distributing branches up there and reach the wastepaper basket or some other place, and do not go where intended.

BRIGADIER GENERAL WYLIE:

They all go to the 201 file. Now are there any other questions on anything covered this morning?

BRIGADIER GENERAL DE WITT:

I would like to bring up the question of time-chartered vessels. Most of our trouble at my Port comes from that source. These ships come back not under military control. The Transport Commander, Transport Surgeon and many of them are absolutely helpless; in some instances are not even allowed to inspect refrigerators. Furthermore, there is not enough personnel on board to feed the sick personnel coming back. In one instance, with ***** patients on a liberty ship, they had to pick up the galley crew to treat the malaria patients. One person after another fortunately had some naval personnel on board, but not enough on board to feed the patients. Men actually suffered from deprivation, but they had complete control of one of these vessels and each ship had sufficient galley crew to take care of it. They had control of putting food on the ship. It is really a serious situation in the San Francisco Port.

BRIGADIER GENERAL WYLIE:

That entire subject of the use of allocated vessels which our agencies operate on our return voyages has been the cause of much difficulty and the subject of many discussions between ourselves on War Shipping Administration. Several actions have been taken which we hope will improve it. We feel, although the War Shipping Administration does not agree with us, that the ideal solution would be round trip allocation for all vessels which are going to carry troops or which are equipped to carry troops or patients on the return voyage. Some improvement has been made. Only yesterday we sent a letter to San Francisco, really as an outgrowth of that one ship you were telling about, asking that you make a survey of all the vessels which are equipped to carry any number of patients, and advise the overseas theater commander that only those vessels will be used for patients so that you will not have an overload placed on some one ship, when possibly shortly thereafter a better equipped vessel will be available. Now I wonder if Commander Terwilleger has anything at all to say on that.

COMMANDER TERWILLEGER:

I would be very glad to. We had trouble and we are very cognizant of this trouble. As a matter of fact Colonel Melton and I have been working for the past ten days, just along the lines suggested now, namely, we might call it the so-called resentment by members of the crew on ships operating under War Shipping Administration, their resentment to be examined and inspected by Medical Officers of the Army.

This was taken up in Washington after a talk with Colonel Melton, and the Division of Operations in Washington sees no reason why any member of the crew should not submit himself to a Medical inspection at any time that a medical army officer deems it necessary, especially food handlers or any other member of the galley crew. It is nice to be here this morning, as it is, to hear about "red tape" and headaches, because we being of the belief that we were going to have it written in the Articles (off the record)--------

BRIGADIER GENERAL WYLIE:

Thank you very much, sir.

Any other questions?

COLONEL MELTON:

I should like to ask Commander Terwilleger when he is going to be able to get that paragraph in the Articles, regarding physical examination. Have they accepted that?

COMMANDER TERWILLEGER:

I'd like to answer that again off the record. (we are working on that at the present.)

BRIGADIER GENERAL WYLIE:

Any other questions?

LT COLONEL FARR:

About casual officers, particularly Hampton Roads, there is a new directive coming out which will probably be in your hands by the end of the week, establishing pools of officers at the Replacement Depots who are being ordered to accompany casual units overseas and to return to this country and take out another casual group. It is an objectionable practice from the standpoint that it means an additional "deadheadening" of personnel. But these officers are going to complete whole trips and their efficiency is going to be based partly on their ability to keep under discipline these groups of enlisted men and casual officers all the way to overseas destination.

BRIGADIER GENERAL WYLIE: Any other questions?

COMDR.TERWILLENGER: I would like to take up a couple of points regarding the Army Transport, The Navy and War Shipping Administration. The main thing is a carry over from peace days and it has always been the habit of shipping companies-I don't say this in condemnation of any shipping companies-it just seems that at all times it's been a plan to assign to any ship a space for a hospital or a sick bay that couldn't be used for any other purpose. You couldn't even use it for cargo. Then the nice thing would be to give it to the Medical Officer. In peace time I was enroute to Europe on a luxury liner. The Senior Medical Officer said: "I'd like to have you visit my Medical Department. I'd like to have you see it

because I am ashamed of the arrangement". And it brought back the same problems carrying over to the present time. A week ago in Washington we were discussing a hospital and sick bay. I was asked not to be elaborate. I was wondering if any of us will be lucky to live long enough to see an elaborate hospital on any ship. I had the privilege of visiting some of the transports and I was very much pleased and impressed with what the Army has done in converting all space into hospital space.

The problem brought up here this morning and the health of the troops when they arrive overseas, I feel, are a reflection directly of two things; Number one, overcrowding; and number two, the amount of available hospital space that is aboard a ship to take care of an emergency. Diarrhea which broke out, as reported this morning by the men, would be directly the outgrowth of overcrowding and lack of hospital space.

I know War Shipping is guilty; I know Shipping Companies are guilty; the Navy is guilty -- but I know the Army isn't guilty of putting persons in hospital space while transports are enroute.

It is a very dangerous procedure. It wasn't stopped in peace time, and it is still going on in war time; and when asked not to do it, they said: "We wanted to put the gun crew in." Alright, we put the gun crew in. It doesn't help it. I would like to ask today if we'd all think seriously about stopping transports carrying persons other than patients in hospital space aboard transports, at any time.

Also another point I would like to ask information on -- that's the return of the hospital ships carrying prisoners. Recently quite a number of War Shipping ships have been transporting prisoners. It was quoted here this morning, there is no need for rush in a port; why overcrowd a prison ship to the extent that they have been overcrowded lately. Overcrowding breaks down all sanitation. It is very important to have the troops, when they arrive overseas, healthy, because that has a direct bearing on victory. It is important to have our prisoners clean on their arrival here, that has a direct bearing on the health of this country, not only the prisoners but this country. We are now concerned in Washington with Colonel Melton's division, handling more ships that are carrying prisoners. We cannot make a success of this unless number one, they stop overcrowding prisoners on these hospital ships; and number two, we have the cooperation which to date we have had of the Public Health and the Army. But there is no reason for rushing in ports. Then I certainly believe we could get some workable plans whereby they wouldn't overcrowd the prison ships.

BRIG GENERAL WYLIE:

I think I can state that already something has been done along that line. I might add that we have been a little bit helpless on the crowding of war ships, as the decisions on how many are to go aboard had usually been made by the overseas theater commander, and he in turn has had to make his decision based upon his local situation. We have had large battle ships come out with no prisoners on and in ten days later on *** comes out with *** prisoners on it. There is another angle from which we may attack that problem that we are now doing, because we are now going to use those ships to go overseas. That is, we are going to provide additional galley facilities and make them more acceptable as troop carriers. I find our time is almost gone. I have just two suggestions I would like to make and I will state that the other question will be brought up at a later period of the conference, on the last day. You may take as much time as you need then.

The one suggestion is that if it is not being done now, very definitely the Port Surgeon together with the Chief of the Water Division should be brought into consultation with the Troop Movement people in discussing overloading. I realize we require and demand overloading because the need for certain of the overseas theaters is beyond our capacity to transport troops, during certain seasons we are required to provide the last possible troop aboard these ships. However, there are certain limits beyond which we may not go. It is absolutely useless to carry troops overseas if they arrive there in no fit condition to fight. So I feel if it is not now being done that they certainly should get the assistance of the Port Surgeon in determining what that overload capacity is.

I will agree that after you have determined you can put only **** on a certain ship and Colonel Farr says **********, it is; but we would at least like to have the benefit of expert opinion; also that the Port Surgeon in coordination with the others prepare some special instructions for the transport commanders on these overloaded ships. I would even differ just a little on the statement of the one ship with the diarrhea, in which it was reported that the primary reason was over-crowding. I take exception to this extent. It was a contributing cause, no doubt, but I feel the primary reason is sanitary discipline, and effective sanitary discipline is much more difficult after you have overloaded and has an over-crowded ship, but still I rather hesitate to give the overloading as a primary cause; a very strong contributing factor, yes.

Have you anything further? (No reply from the floor)

We will assemble at 1:15, I want to thank you all.

LT COLONEL FARR:

This session today is going to principally cover the medical aspects of the meeting. Before we start, however, I have an announcement here that was handed to me. We want to be certain that all officers sign the register downstairs both in and out. Now to start the discussion today.

There is a little subject that has caused a great many questions in everyone's mind from time to time, as to just exactly what the medical responsibilities of the Transportation Corps were. We had some indication at yesterday's session of the command responsibilities and that of technical supervision. The Surgeon General's Office, which acts as the Surgeon for the Transportation Corps, furnished for this conference an officer who has had no small amount of experience with various and sundry arms of the services. Having spent a great deal of time in the Air Corps, he should know the problems we face very much on command and technical channels. Colonel Schwichtenberg is going to discuss this problem.

COLONEL SCHWICHTENBERG:

You have heard from General Wylie, Colonel Farr and Major Griffin who have presented you with the background of activities and responsibilities of the Transportation Corps, with some emphasis on responsibilities of special interest to the Medical Department. It is my purpose to discuss briefly the relationship of the Medical Department to those activities and responsibilities, and to present to you some concept of the Medical Department cooperation necessary in order to accomplish and facilitate these Transportation Corps responsibilities. Now after all, I believe the responsibilities, that is, the Medical responsibilities to the Chief of the Transportation are really fundamentally quite simple. There are those that are common to any Command; measures for the control and prevention of diseases, for the care and treatment of sick and wounded, and, of course, the provision of dental and veterinary service for the command.

In the case of the Chief of Transportation, these responsibilities are materially modified by the character of his organization, in the same sense as Colonel Farr intimated that the same general concept involved in Medical responsibilities in aviation. They may well be divided here according to the mobility and non-mobility of the elements concerned. Now the fixed installations are - we might call it static. Here we have the usual medical services in ports and other station field installations of the Transportation Corps, and those, of course, of all responsibilities common to any fixed command, such as the provision of hospitalization, insurance of sanitation, and in general, the

maintenance of health in the Ports. Also, of course, we must provide for civilian employees the medical services that any employer is required by good industrial practice to make available to his employees.

There is a special responsibility of the Chief of Transportation, which is in regard to the Veterinary service at Ports, and that has to do with food inspection service. This service insures that food products purchased locally, or in many instances merely passing through Ports, destined for the use of overseas troops comply with the requirements. The medical responsibility for mobile outbound units includes of course, you all know, the screening out of individuals enroute overseas who are not physically fit for such service, who have been overlooked by home station of origin, or have fallen victim to some in-current or temp- ary disease.

We had some discussion about this thing with General De Witt yesterday, and it is something that is very close to me personally. I feel - and this is only my personal belief but I share it with quite a number - that when a man arrives at a Port or staging area, has disability such as hernias, pernicious sinuses, tonsils, and what not this represents in each instance a failure of the medical department, which I believe is attributable directly to the surgeon in command of the stations from which these individuals originate.

I believe that it is fundamentally sound to say that all of these individuals receive a thorough physical examination, if possible, prior to the beginning of this period of training which culminates at the port. This to my mind is a great waste, and there is still another angle to it which I think is important. The Surgeon General does not believe that in the event that a soldier, seen at a port who has a hernia or pernicious sinus, should be CDD. He believes that man should receive corrective surgery. Now where that corrective surgery should be done is a very real problem, and I don't believe that the port facilities in many instances will be able to accomplish all of that. I think that there is organization available for such individuals to be returned to their posts. They certainly can be returned to some nearby station or general hospital. Any time that any difficulties along that line are encountered in regard to bed credits, it is only necessary to call my Evacuation Division, and we'll arrange for the necessary bed credits, as necessary,

Now in addition, we have medical responsibilities in these outbound units to prevent the embarkation of individuals, who because of communicable diseases might be dangerous to the health of others who are embarked on the ship. Aboard each ship must be placed sufficient medical supplies, personnel, and equipment,

in accordance with recommendations of the Surgeon General, to see that these medical responsibilities can be properly carried out. The transportation necessary for the proper employment of supplemental personnel required for the care, treatment and safety of patients expected to require evacuation from overseas is also one of the medical responsibilities.

Now on ship board which of course is another phase of this responsibility, it is required that essentially the same medical service be made available as to a fixed command on land. This includes the care of the sick and the wounded developed in transit as well as those being evacuated later on when the ship is inbound; in that latter instance, when they reach this side, to have insured that these individuals who are possibly potential carriers of infectious and communicable diseases are properly cared for, and also insurance of proper facilities for care of patients evacuated from overseas, and their care until turned over to service commands.

We have had considerable difficulties in this particular problem in regard to officers returning from overseas, who have lost their papers, and who are without funds. That's a condition which occurred sometimes in the last war and certainly has already occurred now. It can be expected to recur in this one to an increasing extent as the war progresses. After all many of these officer patients have to be transported by hospital train, particularly if they arrive at a port such as Boston, to the nearest general hospital which is some distance away. There are meals to be furnished these individuals, or they have to be fed I should say. The question as to how that should be done has arisen. It is a particularly difficult question when you stop to think of complications involved. These officers have been overseas where they could always arrange to be fed at some mess. When they get here they feel, after all is said and done, they have been wounded overseas, they should receive meals and other necessities without further arrangements. Yet the only way they can be fed is from the dining car which is the same source of food as the rest have. And of course the enlisted men are issued meal tickets. In the case of officers, however, you can't issue meal tickets and the result is that hours after they have gotten on the train, meal time comes around and they have no funds. There seems to be no way to feed them. That has not been solved yet.

There are several possible solutions to make arrangements so that these officers can be issued meal tickets for that purpose. That is, as you all realize, quite a departure in policy. The Quartermaster is not interested in making that departure in policy, though it may be necessary to do just that. Another temporary solution, which I don't believe should be our final

solution, but one that should help, will be to have the Port Surgeon insure that the Red Cross is able to contact these officers and make suitable loans. I don't like that system at all, but it will enable them to buy a pack of cigarettes, or to get a meal, in the interval between the time they arrive in this country and the time they have been able to get their finances arranged, when they reach the general hospital. At least it will prevent some suffering.

There are tremendous implications to the command responsibilities of the Chief of Transportation. The lack of sufficient attention to these command responsibilities in their ports, and of the Port Commanders, would undoubtedly result again in wide spread epidemics in the staging area with the troop movements outward. In addition there would have been shipped overseas large numbers of men who have been manifestly unfit for service, and their immediate return to the United States, of course would put additional burden on our transportation facilities. As I mentioned before, it is not the policy of the Surgeon General to have these individuals, who are unfit, received a CDD. I can't stress that enough, because it was one of the things he was very emphatic about at one of the recent conferences.

Frequent outbreaks aboard ships of air, water, and food bourne communicable diseases with resultant comparative incapacitation of troops as they arrive overseas would have been prevented. Also, lack of facilities for the care of the sick and wounded arising enroute, and lack of facilities for the care of the sick and wounded arriving from overseas. The proper utilization of ship platoons might be considered at this point. There has been a good deal of "grousing" I suppose that would be as good a word as any - on the part of many of these individuals on these ship platoons, particularly nurses and doctors, that they were not doing anything, they were sitting around. At the same time there was a great shortage of doctors and nurses. So we have here a paradoxically situation. I believe that some arrangement will have to be made to utilize these more fully. However, I also realize, well realize, that recently this condition has more or less corrected itself because of the fact that they are being shipped out and now more nearly completely utilized.

It was the plan that ship platoons in ports should be utilized by the Port Surgeon in the various installations as far as possible. With returning personnel (civilian, military and prisoners-of-war) the importation of communicable diseases into the United States represents a serious problem, and failure on the part of the Port Surgeon to combat this, or cope with this situation, would have resulted and still can, if it has failed, in the importation of serious new diseases into this country. The fact that there has not been by far and large any note-

worthy failure in any of these respects, indicated that these command responsibilities have been discharged in a complete manner; and this would not have been possible had there not been a realization of, and a great deal of effort to take care of these responsibilities by all concerned.

COLONEL SCHWICTENBERG:

These Command responsibilities have been discharged in an excellent manner. This would not have been possible had there not been a realization, and a great deal of effort from all concerned to take care of these responsibilities. Now in considering "all concerned", I don't limit myself to Port Commanders and their Surgeons alone, but almost every officer associated with the Port. The cooperation of everyone of these individuals is the thing that has been responsible for the excellent results that we have had so far. We have had good coordination and cooperation among all of these individuals, but as the tempo of the war increases and particularly as the movement of personnel is increasingly inbound, there will be even greater need of cooperation and coordination between all of these individuals charged with those responsibilities. This has been in vision by the Chief of Transportation and the Surgeon General and to provide for it, it has been mutually agreed that the Surgeon General will act as the de facto Surgeon for the Chief of Transportation.

The Chief of the Hospital Administration Division will coordinate all Transportation Corps matters referred to the Surgeon General's office, and will generally supervise all Transportation Corps matters of interest to the Surgeon General. Under the Chief of the Hospital Administration Division, the Surgeon will be represented by a liaison officer -at present- Colonel Fitzpatrick detailed to the Office of the Chief of Transportation. He will, as a representative of the Surgeon General, directly advise the Chief of Transportation on his responsibility where these recommendations are given in accordance with known policies or procedures which have been prescribed by the Surgeon General. He advises the Chief of Transportation after consultation with the proper agency in the Surgeon General's Office when the recommendation involves a change in policy or in approved procedure. On the inauguaration of new policies or procedures where coordinated action by the Surgeon General's office is required, he keeps the Chief of Transportation informed as to the status of his command medical responsibilities, and this is necessarily based on information that he receives from the various Ports. He assists in the necessary coordination with those concerned on medical matters referred through channels to the Chief of Transportation when the decision reached must be based both on technical

medical consideration and command considerations. The ultimate purpose of this arrangement is to effect a uniformity of medical policy in the several Ports to provide a properly coordinated channel which Port officers may utilize to secure medical decisions and generally effect proper technical medical supervision for the Chief of Transportation.

If this or any other administrative arrangement is to function efficiently as it is intended, it is essential that cognizance be taken of proper channels of communication. These were touched on very briefly by General Wylie yesterday. What constitutes proper channels under this setup is not often easy to define since the arrangement is somewhat unusual. It is, of course, not desired that purely routine medical matter of no command interest be forwarded to the Chief of Transportation, but it is essential that matters of any command interest be forwarded through channels so that proper dissemination of information and coordination of decision may be effected. The best guide for making a decision as to the way it should be forwarded to the Chief of Transportation and what may be properly sent directly to the Surgeon General's Office, is contained in Paragraph 11, AR 340-15 which states: "Communications relating to the initiation of new or changes in existing policies and regulations, or those requiring decision or action affecting the command as a whole, will be routed through normal military channels of command. Communications other than the above, routine in nature, whether from a subordinate to a superior or vice versa, may bypass intermediate headquarters whenever it is apparent that intermediate headquarters are not interested and no action by them is required. Communications will not be routed through a headquarters which has no interest in the matter and which is not expected to intervene therein." The only addition to the above statement of principle - to base decisions regarding the routing of communications - is that matters of command interest whether inquiring decisions or not should be routed through command channels, and command channels will always include the office of the Chief of Transportation where medical matters are concerned. Now this is very simple; in the arrangement of matters in the office of the Chief of Transportation there is very close liaison between him and Colonel Fitzpatrick so that he will certainly receive these right away. It is only through adherence to these apparently unimportant administrative details that one can obtain the proper coordination of action and dissemination of information, and avoid needless conflict of interests through misunderstanding. Often times it appears that people are fighting each other almost as much as we are fighting the war. In the last analysis each Port is a separate Command - in effect that is a separate service command having under its control several staging areas, sub-ports, and transports assigned or attached to them. Under the Port Commander the Surgeon has the usual functions of any Surgeon of a command. In addition to such functions as are

prescribed for the Surgeon of the Corps Area or the Service Command now suitably modified in accordance with the existing organizational policy, inasmuch as each port surgeon has available only a small technical staff - it is believed by the Surgeon General that he call upon a surgical, medical and sanitary consultant of the Service Command in which he is located. That has not often been done, as a matter of fact, but it is the Surgeon General's wishes that the Port Surgeons take advantage of those technical staffs that the Service Commands have available.

All technical matters should be processed through the ordinary technical channels and these of course will include the Port Surgeon. He is therefor responsible for direct, general, technical supervision of medical activities and of all Port echelons. Of course, proper attention must always be paid to the command. It is believed adherence by the Port Surgeons to the broad general principles outlined will enable the continuation of excellent results under the more severe conditions which will certainly obtain as the war progresses.

The current arrangements between the Office of the Chief of Transportation and the Surgeon General and the arrangements now in process for technical, medical, surgical and sanitary consultants as required from Service Commands will, I believe, enhance the uniformity of medical policy, and the soundness of scientific medical procedure in all command echelons of the Chief of Transportation. There has been a considerable discussion of the matter of personnel. I believe that too few of the officers in the field realize how serious the situation is insofar as medical officers and nurses are concerned. We don't have it scheduled on our program. I have tried to hurry through this part so that I could give Colonel Padan who heads the Personnel Section in the Surgeon General's office a chance to talk to you very briefly to give you his slant on his personnel problem which, of course, is one that all of us have.

Will you come up here, please?

LT COLONEL PADAN:

Gentlemen. I think that most of the Port Surgeons realize that we have a shortage of medical personnel. By that I mean Medical Corps Officers and Nurses. I don't believe that all of you know the seriousness of the situation and what we will face in the future. To put it bluntly, we have been "on gravy" up to now. To orient you briefly; in our former scheme, where we thought that we could give the old-time medical service the way we started out in the War, we needed approximately 6,500 doctors. Beginning in December of last year and continuing through January of this year, the War Man

Power Commission began to enter into the question. It went up through the Chief of Staff and the General Staff and along in March, there was handed down to us a figure "out of the hat" so to speak, that there would be only ***** doctors available if the Army went into ***** men. We have gone on that assumption and as you will remember, along in May and June, allotments to all installations were revised.

In our station hospital of a thousand beds, we went down from an ideal of *** doctors to ***. That applied to all Service Commands and to the Chief of Transportation, and also to the same extent in the Army Air Forces. In allotting the ***** when we made that reduction, there were still a thousand more positions allotted in the Army Serive Forces than we had. We hope to make that up by the natural process of attrition. We have closed two Medical Replacement Training Centers and a few things of that nature, and the Army Ground Forces program did not get as big as was expected. The Army Air Forces had a little cut back and we thought that we could make that here within the last few weeks.

The General Staff has been considering - this should not be publicized after you leave this room **********(off the record)

As you know, we actually have approximately ***** doctors. Some ***** are overseas. Therefore, how are we going to get doctors and how many are we going to get for the hospitals? How many are you going to get for the transports? We are now presented with the problem of rendering a maximum medical service with a minimum of personnel. It will probably be a medical service that will be often of vital interest to you. Up comes the question of how many doctors are we going to put on transports. What is the policy going to be? It has not been definitely decided, but it is doubtful if it would be a desirable policy to carry a non-commissioned officer and no doctor. Up to now it was supposed that we would get doctors at the rate of *****a month. In addition to that, we were supposed to have gotten all interns that were commissioned. Actual procurement has run around **** a month average for the past year. Last month alone we had separations from death, sickness, and other causes totaling ***** so we have ******. I do not know but I would like to get the reaction from the floor. I can assure Colonel Schwichtenberg and Colonel Fitzpatrick as to what the Port Surgeon thinks is the biggest vessel that can be safely run carrying troops without a doctor. We have a lot of things to consider. The Navy uses a destroyer. As I understand it they have no doctor. They have no doctor on the submarine. We do not want to use an officer that is too "green", but it has gotten down to this point. We are seriously considering taking the second doctor out of the combat battalion. This means sending that battalion into the front line to actual combat with one doctor. Now another thing about the nurses, we still have hope for nurses. We shall be limited. We have been limited to a certain extent as

to the number we might hope to procure. The nurse situation is improving slowly and with Army Cadet Corps or whatever this Nurse Cadet Corps is, it will probably pick up in due course of time. We have definit hopes by the early part of next year of meeting our procurement objective from there. That is all I have. I would like to hear an opinion from anyone who might like to voice one on the transport problem.

COLONEL SCHUHMANN:

Colonel Padan, I would like to ask a question. You asked an opinion from the floor as to what the smallest transport is that should carry a doctor - the biggest one that can get by without one. You gave some figures. That would be roughly about one doctor to every **** men, wouldn't it?

COLONEL PADAN:

Well, they want us to reduce it. It runs down now to one to **** men.

COLONEL SCHUHMANN:

Why can't you use that as a guide? On the transports, if you are going to put on ***** men you are going to have a crew that is going to be more than *****.

COLONEL PADAN:

You can't use that for a guide because **********.

COLONEL WHITE:

One thing I would like to point out. The largest transports operating actually have only **** doctors.

COLONEL LOWRY:

We should keep in mind the use of these Liberty Ships and set the policy so that it will bear a definite relation to these, which we are using for our transports. In other words, they are going to be somewhere in the capacity of those ships.

GENERAL DE WITT:

I think the capacity of the transport is the factor, which, when you asked the question, what would be the maximum capacity we could put on an enlisted man.

GENERAL PADAN:

Yes, sir.

GENERAL DE WITT:

That depends entirely upon the type of enlisted men you put on the ship. We can't go out and put a technician on a ship and expect him to do the work. Now if we are going to be required to put enlisted men on these ships as we probably will - up to *** or *** men - we have got to get them in the Medical Department in number of quantities. Now if you are going to do that we should plan ahead, establish a school, one or more schools, utilize our technician schools and require a course of training to properly select men that we could trust there, with that proper training. You could send a ship from our port with up to 3 or 4 or 500 patients providing they ship troops in a convoy, and they have available a doctor from that convoy, but the main thing is to get the proper type of men. We pick out a man he is classified as a technician. I don't think he can handle that business. If we can establish a technician school at **********, pick the men carefully with educational background, if possible, some training in biology and give them a course of instruction.

COLONEL FITZPATRICK:

I think we can get by with less doctors with respect to the medical point that it might be possible to reduce your requirements if you put only one doctor in a convoy. I do not think that the average convoy is going to stop particularly if it is in dangerous waters for the transfer of patients from one ship to another. To put the people on the ship where the doctor is. You cannot risk the life or lives of others or individuals for the life of one individual no matter how much you want to.

GENERAL DE WITT:

I did not mean to infer the transfer of patients in a convoy, but I do mean, use the same system as the Navy uses. Be able to transfer a doctor and be able to take care of patients on various ships.

MAJOR QUINN:

I heard some of our convoys do that.

LT COLONEL FITZPATRICK:

You have a convoy of 20 ships. If you want to transfer your doctor from ship to ship that would mean 20 stops. I don't think they could establish that.

COLONEL PADAN:

One other thing I would like to bring up for consideration and leave open. I do not want to take any more time. The opinion of the TMD as to the possibility of disbursing outbound doctors has got to be reconsidered no matter how much leeway you have. I know they are all going to the same

place that is one thing that is probably going to be mandatory to use all casuals that you can within your limitations to provide medical services on these outbound boats.

LT COLONEL FARR:

Did you have any further question? Colonel Schwichtenberg got out from this thing very lightly.

COLONEL SCHWICHTENBERG:

Let me also make a statement here that in making up this program Colonel Farr, from the Office of the Chief of Transportation and who I believe knows a great deal, I know he knows a great deal more than I do and I believe who knows more than anyone else does about this general problem. He has not included himself in this thing.

LT COLONEL FARR:

Any discussion on these responsibilities.

COLONEL MELTON:

May I ask a question? I think there is one thing that needs a little more clarification. Now Colonel Schwichtenberg mentioned the staging areas receiving patients. We would like to know exactly how we are going to handle these if you get a hernia and they have facilities in the staging area to operate. Shall we operate?

COLONEL SCHWICHTENBERG:

Yes.

COLONEL MELTON:

Now in our staging area we have two large hospitals, and we can operate, and in the natural course of events we expect them to be back to duty within 90 days. Now shall we utilize our surgeons, and we have excellent surgeons and facilities in these staging areas, shall we do that or shall we transfer all of these out to a general hospital?

COLONEL SCHWICHTENBERG:

Certainly I do not believe that comes under this term surgical procedure which we have in the War Department and do I know that after all is said and done that hernias are being operated on in these station hospitals all over the country why then shouldn't the same thing be done at the Staging Areas' hospital. Provided only one thing. That you don't get tied up to the point that you can't take care of situations that recur in your station. That in my mind that's

the only thing that will hold you up.

LT COLONEL FARR:

Well, gentlemen, there is one thing to mention to you. Tomorrow morning we have an opportunity for the discussion of all problems. Now in order that the session will be a fast moving one and also one with good answers, I would like to have you keep such notes on questions as you may have down on this session. Write those questions out and give them to us at the close of the day. We will refer them to the proper officers this evening and they will do allittle work this evening, I hope, and come up with the answers that are necessary so that in our discussions tomorrow we will have the best answers possible on these questions. There are some things that have not been covered fully this morning that I want to know. You will want to ask further questions so keep records of these things and turn them into the desk here this evening covering any subjects that have been talked about or if you have got some things that have not been discussed that you want answers on or want to bring up for discussion tomorrow, let us have those. If we do not have time for them or we are unable to get an answer, we will take them back to Washington, work out some answers there and publish them to all concerned. It would be a good idea to put down on paper, right now, some answers to the question that Colonel Padan propounded, and that is doctors on ships. We should have the opinions of all ports on that and now is a good time to start getting them.

Now the next phase of our mornings session is the result of the Port Commanders conference at Boston. At this conference there was considerable discussion about Transport Surgeons. The Port Commanders decided that they wanted a uniform regulation for transport commanders. It was so written in the minutes of their meeting and General Gross directed that we have a conference for the purpose of working up such a regulation. That was the primary cause for this conference, the motivating force that brought it about, although we have been discussing having such a conference for the past six months.

Now to discuss the medical transport regulations, you can go into hours and days, if we take it piece by piece. Therefore, we have picked on the regulation that is most voluminous and the

most detailed, and whether it shows the most work, I don't know, but it certainly shows a great deal of work. We picked on that regulation and we sent it out to all of you for study prior to the conference. We assume you got it and had a chance to go through it at least hurriedly. We are now going to have the presentation of that regulation in rather brief form this morning, having about an hour allocated to discussing it.

Following that, we will have open discussion tomorrow, and at that time we will have further discussion on the regulation.

Now in order to get the thing covered, it is going to be necessary to select a small group for a little special duty to actually sit down and gather all of the comments that we get out of this meeting with such decisions as we reach, and come out with the finished regulation. Making up one of these things is no simple job. It takes a great deal of research and experience, both experience of the individuals who write it and the usuable experience of the personnel under his control, and with whom he is associated. We are going to have for this presentation, Colonel Schuhmann, from New York Port of Embarkation.

LT COLONEL SCHUHMANN:

Colonel Farr, General DeWitt, and fellow officers. I think Colonel Farr has made a pretty good introduction here. We have several of our regulations here - - - regulations, as Colonel Farr called them - - - I prefer to call them instruction. If anybody desires to have one, we can have them distributed. I don't know if each officer brought one with him.

The greater part of this next hour will be taken by discussion. It is my intention only to make a few pertinent remarks merely as an introduction. As General Groninger mentioned yesterday, we are going to accomplish in 2½ days what ordinarily would require 2 weeks. Because of the enormous volume of material to be discussed regarding instructions for Transport Surgeons, an attempt will be made this morning to direct this discussion to the proper channels, so that the primary mission of this hour may be attained.

The object is to decide the type of material which lends itself to becoming standardized instructions for Transport Surgeons. For the past few days I have been hurriedly reviewing the various instructions for Transport Surgeons from the different Ports of Embarkation. I have been struck by their similarity and their tendency towards uniformity. Further, I have noticed that with each change published at the various ports, there has been more and more tendency for all of these instructions to become similar.

In reviewing any instructions from the various ports you will find that each contains some instructions which are taken word for word from the other ports. Yesterday, General Wylie remarked that it is the desire of the ASF to standardize procedures throughout all of its agencies, and he remarked that the Transportation Corps is making every effort to attain this end without actual interference with operations. In view of this, I believe, it appears appropriate at this time for Port Surgeons to select standard instruction to cover all Transport Surgeons and to have these instructions published by the Chief of Transportation. In addition to reviewing the instructions for Transport Surgeons published at the various ports, I have also reviewed current War Department directives and pertinent Army Regulations, and it is my opinion that in these Army Regulations and War Department instructions, only minor changes are needed.

These directives and Army Regulationstell what the duties of the Transport Surgeons are. It is believed that this should be augmented by instructions which tell how to accomplish these duties, and that is all that we intended our instructions at the New York Port of Embarkation to attain. We wanted to tell how to do what has to be done. Later on you will see why ours are more or less voluminous. They aren't directives; they merely tell how. As Colonel Farr told you earlier the Commanding General, New York Port of Embarkation, recently forwarded to each Port of the United States, -- to each Port Surgeon of the United States rather, a copy of the instructions for Transport Surgeons as published at this headquarters.

It was published with a view to having each Port Surgeon become familiar with itscontents so that it might be discussed at this meeting. It was not furnished, I might remark with the intention that it be adopted at each Port nor with the intent that its contents be accepted as an ideal to follow.

It is merely to be used as a guide because we have to have some standard from which to work. Because we are using the New York Port of Embarkation instructions as a guide, it is believed desirable at this time to briefly review the history concerning these instructions with a view to showing the need for such.

I will go back to peacetime. It was customary at the New York Port of Embarkation for the Port Surgeon to give oral instructions to Transport Surgeons prior to an assignment to a vessel. However -- and I believe the most important fact was that we had an experienced medical detachment aboard each ship, the first sergeant of which was thoroughly familiar with routine administration. It was merely a matter of time before the Surgeon in turn became familiar with this administration. Following the declaration of war, however, it became necessary

for the Port Surgeon to continue his oral instructions, but the large number of Transport Surgeons assigned, made it necessary to supplement these oral instructions by information in writing. Before long we noted that we had a large number of written instructions. As they became more and more numberous it was finally decided to compile them into booklet form and this was first accomplished in New York in May 1942. As the Port Surgeons Office in turn increased in size and became more and more specialized, it was divided into sections such as, Supply, Transport Inspectors, Personnel Section, Evacuation Section, and the need for special information in each of these sections became evident.

Now items were added to these instructions until repeated mistakes on the part of the Transport Surgeons, or, in particular, ommissions on their part necessitated the publishing of specific instructions. As a result it can safely be said that at the New York Port of Embarkation there is, or has been, an absolute need for each item present in this booklet. Undoubtedly the same conditions have existed at other ports, and the interchange of information between ports brought about by the visits of Surgeons has resulted in a uniformity of these instructions to which I alluded earlier. It is suggested that this new instruction contain overall information for Transport Surgeons operating out of every Port. It is believed that supplements containing information peculiar to the various ports may be added as the necessity arises at the individual ports. In all probability it will be possible to incorporate the good points of the present instructions that are published at the various ports in the United States as it becomes evident that the material contained within these instructions should be permanent in nature.

Now, when I say permanent in nature - I don't mean it won't be subject to change maybe in one month, or six months or one year - I mean it should be an all-year instruction. We made one mistake at the New York Port in our instructions, for example: on the use of atabrine - - atabrine is to be used in our instructions between the months of May and October; that should not have been made part of the permanent instructions. The instructions should be applicable to any transport carrying troops from our smallest frieghter to our largest transport. It should be an elaboration on how to accomplish the requirements of the current War Department directives and Army Regulations; it should be concise, and have a degree of elasticity. This degree of elasticity should allow for the addition of instructions peculiar to various ports. Now I think it is most important that it should be logical in sequence, and it should be well indexed.

By making continous additions which become very numerous in a short time, and are not included in the index, we lose the whole point of the instructions and we have found that Transport Surgeons can not find or do not refer to the written instruction.

A : As to the reasons for the publishing of a standard instruction, it is believed the following is sufficient: first, it is the desire of the Commanding General of the Army Service Forces and second, it is the desire of the Chief of Transportation; and I think these are reasons enough. If they desire uniform instructions I can see no reason why we should say, or anybody say, we can't have them. If we do have uniform instructions, it is believed that the following advantages will be obtained therefrom: One, it will facilitate the training of personnel prior to assignment to transport, personnel will have something to work on when they arrive in the port, and we can make up a standard training program which will include all these instructions. It will facilitate the exchange of personnel between port.

At the present time, the way our transports are operating, personnel is permanently transferred to the port at which the vessel is assigned. Certainly if the Transport Surgeon runs into uniformity in handling his material at one port, he will fit into the other port much better. It will help him overcome the administrative difficulties when he is assigned to these other ports or upon his return to a port other than his home port.

Now, in the event a large number of Transport Surgeons are suddenly needed, there will be a standard guide for reference. Along that line we might remember that Colonel Lowry mentioned a little earlier the fact that they are "blowing up" a lot of freighters to carry personnel and in much larger number than formerly. That means that we may suddenly have to put a large number of transport surgeons aboard these vessels, and we will not have time to train them in our own offices, where we do not have a pool nor the authority to carry these people as overhead. I believe further, a standard instruction would tend to make uniform reports, so that these reports would be much more understandable at central agencies - such as the Office of the Chief of Transportation - when they arrive. It would facilitate the ability of each Surgeon to accomplish repair, secure supplies, and change personnel, etc, when they arrive at strange ports. Lastly, I believe it would tend to standardize medical care aboard transports. Now, that may sound rather odd. But I do believe, and we have seen it here at the New York Port of Embarkation, that some Transport Surgeons are performing work that is not necessary ---performing elective surgery. In particular, I believe they are not handling mental cases to the best advantage of the case, themselves or the Service. Every Transport Surgeon has a tendency to bring his mental cases on deck and give them a little air, and we have a case where on one convoy, three of them decided to go over the rail. Open ward cases cannot be treated on transports the same as they are treated in a hospital. I believe we should give them specific instructions on how to handle these cases. It should be based on the experiences of the various Port Surgeons,

because they are certainly in a position to see what happens more than the individual Transport Surgeon. We have found in New York, when assigning temporary Transport Surgeons to vessels - which we have done recently - that there is a very marked improvement in the work performed by these officers when they are given instructions prior to sailing. They come into our office, if only for one day, to receive oral instructions.

Keeping all of these above points in mind, I believe it desirable at this time to discuss the contents of the manual which we have at New York, because it was forwarded to each Port Surgeon and discuss some of its contents as to its applicability at other Ports.

These are all the remark I intend to make on the subject because, as we said before, it is too large a subject and would require too much time. Now you will note at the New York Port of Embarkation we have published a bound copy. It is bound, which may not be too good a policy. It is indexed, and it is divided into certain sections so that it will be easy for the Transport Surgeon to refer to these sections. In other words, we want to make this inforamtion available to him. We have tried giving him the Army Regulation, War Department Circulars, and Surgeon General Circulars, but he does not refer to them. If we can give him in one compact form an instruction that will cover most any problem that might arise for him, I believe we will attain our end. Now if each of you has one of these instructions from the New York Port we will go through it. I would like to have any comments, and as Colonel Farr mentioned if there are any comments, they can be made in writing, to be turned in, so that we might study tonight with a view to making further remarks tomorrow.

In Section I of this instruction, we have provided merely general provisions. We have tried to tell the Surgeon in these general provisions what his hospital is, how many patients he should have in it, how many beds he should keep open, and we have referred to the pertinent Army Regulation. I think you will find that same instruction in almost any instruction published at the various ports. We have tried to cover secrecy. Large reports come in stating each port that the vessel has touched, and it is believed desirable to have these documents classified.

LT COLONEL FARR:

We ran into some difficulties, I recall, at our last conference, due to some new regulation put out by the Administrative people of the ASF or somebody, stating that you can't publish types of regulations, instructions,

or something ot that nature. Will that apply to the publishing of something along this line? Colonel Heiskell will have to modify the title of it, or what exactly is the standing of this particular thing?

COLONEL HEISKELL:

I think that is just a technicality and I don't think it will apply to this.

LT COLONEL FARR:

The question I have in mind is whether this should be issued as a War Department Circular, an Army Regulation, a Transportation Corps directive, or a guide? I am wondering if our administrative problems in ASF would have any bearing on that or whether we can decide ourselves what would be the most useful.

COLONEL HEISKELL:

I think we might have to get some administrative advice before we finally decide, but from the standpoint of distribution, I think it would be better to get it issued as a War Department Circular, or as a guide put out by the War Department that would give it distribution abroad to all the ports of debarkation. I think it should be disseminated that far. We ran into that recently in the salvage matter aboard vessels. We had authority to issue it as a circular, but I was convinced it would get better distribution as a War Department Circular.

COLONEL SCHWICHTENBERG:

As a War Department Circular, however, you don't want this thing to go to everybody, but just to a small group, so why is it necessary for it to go all over?

LT COLONEL FARR:

I think Colonel Bradish might have something on that. Quite frequently our vessels get down to some of these other places, and they completely disregard any instructions ever given by the port insofar as what can be put on. A wide distribution would help, would it not, Colonel?

COLONEL BRADISH:

The only reason I see basically for publication of this type of guide or memorandum or directive --whatever we choose to call it, is that it is going to be subject presumably to such frequent revision and correction that, that would argue the validity of publishing it as a circular. Presumably, also, each port will have an appendex or attender or supplement to this directive to cover certain local minor administrative requirements for that port. For that reason, I would be inclined to think that as a Transportation Corps directive, it could be handled with a little more facility and your changes could be made, and I think it still could probably get in the appropriate hands overseas. However, you may feel that it should come from the War Department to those overseas commanders, and of course, the only way that could be done is by having it a War Department Circular.

LT COLONEL FARR:

Possibly we can take care of that in a little different manner. I am inclined to think, Colonel Heiskell, that we are going to have frequent changes in this, although the changes are going to depend on what form we decide to put it in. If we decide to keep it general, we won't have as many changes. However, I believe we might be able to get the General Staff to put out a War Department Circular or an amendment to present instructions directing the Chief of Transportation to publish such a thing and that this will be the valid regulations for the job. It will be up to us to keep it up to date, so that we have in the Oversea Theater the directive, to the effect that a set of instructions will be published by the Chief of Transportation which will be sufficient authority for them to stick, and it is then up to us to publish them. We may be able to do that. But I believe, General DeWitt you are having difficulty with personnel coming back from overseas, not in accordance with the way you think they should.

BRIG GENERAL DE WITT:

That is correct.

LT COL FARR:

Are there any instructions which you put out that perhaps are not given the credence in the Pacific you would like them given. We should have some weight behind this to enforce the regulations we put out.

Do you have any further questions or comments on this matter now?

COLONEL LOWRY:

Would it not be very simple to handle changes regarding local conditions, authorization for which will be in the instructions themselves - for local changes to be made by each local commander?

LT COLONEL FARR:

That is opening the way up, I am afraid, for too many changes that are not entirely orthodox.

COLONEL LOWRY:

That would be authorized by the Chief of Transportation.

LT COLONEL FARR:

I wonder if that will be necessary?

MAJOR QUINN:

I am sure it will. There is so much variance in looking over the memoranda they have and the one we have, there is no similarity at all and there can't help but be a tremendous variance of opinion.

LT COLONEL FARR:

Are these basic variances or ------

MAJOR QUINN:

I believe a good deal of it is basic.

LT COLONEL FARR:

Such as?

MAJOR QUINN:

Well, for one thing, we include no professional instruction in ours.

LT COLONEL FARR:

Is it objectionable to put professional instruction in?

MAJOR QUINN:

We believe so, yes.

BRIG GENERAL DE WITT:

Professional instructions vary from time to time with professional procedures. They could be carried in a separate memorandum from each office and not included in this. One day you treat malaria cases one way, and another day the Surgeon General comes up with a circular and changes the method. It is always subject to variance from day to day. I personally feel that the regulations themselves should be purely administrative and the professional instructions are something that could be changed from time to time.

LT COLONEL SCHUHMANN:

I commented a little earlier here that we made mistakes in ours. I do think though that it should include treatment of mental cases, that is, the actual handling of these cases.

BRIG GENERAL DE WITT:

But not the drug treatment or how much sodium amytal you give.

LT COLONEL SCHUHMANN:

That brings up the whole subject again. We have attempted to tell these people how to "dot their i's". We have gone into detail. We have told them exactly how they will do things, and the reason for that is because they did not do them or did not perform them properly. Therefore this is merely an instruction.

MAJOR QUINN:

You may want them to "dot their i's" a little differently than we do. Our whole supple problem differs. In yours, you ask them to make out a requisition. We ask them to make out a list; the requisition is made out in our office.

LT COLONEL SCHUHMANN:

It is the desire of the Commanding General, Army Service Forces to standardize this.

MAJOR QUINN:

Then we will have to standardize it.

LT COLONEL SCHUHMANN:

The only answer to that as I can see is that we will all have to give a little bit. The advantages of it, as I pointed out, were some eight or nine in number. Nobody has criticized those. Now, I will repeat some of them. It will facilitate the training of this personnel, so that there can be an interchange of this personnel between ports. It will overcome administrative difficulty for the Transport Surgeon upon return to ports other than the home port. In the event we get a call for a large number of Transport Surgeons suddenly, there will be a need for standard guide. It will tend to make this report to be received by the Chief of Transportation uniform so that he can properly interpret it. It will facilitate the ability of each Surgeon to accomplish repairs, secure supplies, and return personnel in the port. It is done differently in every port at the present time.

BRIG GENERAL DE WITT:

I think there can be no question about the value of standardization. It is just a question of the type of instruction we get out. The only point I raised is the question of including in a War Department publication of that kind, things that were not standard -- like medical treatment and various things like the handling of mental cases--- you can lay down certain principles. I am not criticizing yours at all, but just the general makeup of these regulations. I don't think we should go so far as to say what treatment they should give under any conditions except the general handling. Remember the fact that our Transport Surgeons are graduates in medicine and have been practicing medicine. We can say a mental patient should be kept below deck; at certain times restraints will be used, and at certain times restraints will not be used. Whether we should give them packs or continuous seconal or sodium amytal, is a medical matter, that I think, you should leave to the judgement of the Surgeon. Based on procedures outlined by the Surgeon General's Office, this is not a criticism of your or anyone elses. Just general principals, I think, should be considered when we get up these standardized regulations. I don't think anybody can doubt the value of them. Every port varies in certain things. Every port has good things and every port has bad things, --not bad things, but things not as good as at other ports. If we can get the best from all of these, it would be a big step forward.

COLONEL BRADISH:

I think it is wise to have a general standard operating procedure from an administrative standpoint, as these vessels and the Surgeons go from port to port and from

area to area, throughout the world. I do feel, however, from my standpoint, that these directives or these instructions, should be reasonably general. I think we are treading on a little bit of delicate territory here perhaps, and superseding the local commanders' problems. I think we should be careful. I do think that certain jurisdictional discretions should be left to the Port Commanders, and I think also the Port Surgeons should have some discretionary jurisdiction in their local problems and policies. I don't think there are any two theorists that have precisely analagous professional problems. I think a good many of those policies should be handled locally as General DeWitt says. After all, we are dealing with doctors and a variety of surgeons whose policies are a little different. I don't think we can standardize the practice all over the world with such a directive as we had in mind here. That is where I think the supplement to the general pattern laid down should be used.

MAJOR GOPLAN:

I have a suggestion to make. I think the general instruction if it's going to be issued should be limited to the basic administrative problems and should definitely not contain the professional subject. But I also think that in accordance with what Colonel Schuhmann has said there are many surgeons who although they are fundamentally doctors, have not had experience on transports. I think there could be an addendum put in the back, not as a directive, but as a summary of the experiences other transport surgeons have had; if certain procedures have worked out very well with some surgeons they could well be adopted by others. A lot of things happen on transports that do not happen in general practice with which they are not familiar. I think they can well take the advice of other surgeons, but I don't think such advice should be issued as a directive.

BRIG GENERAL DE WITT:

That was the very point I made. It isn't a question of putting these things out to people, but putting them in a War Department regulation which would necessitate publishing any change. Make that a separate bulletin, or memorandum, and take these professional matters up in that way.

COLONEL SCHUHMANN:

General DeWitt, in a way I think you made a very good point. These are the types of points, I think we will need if there is going to be a committee to rewrite these suggestions. Colonel Farr suggested that they be written and

so that they may be discussed tomorrow. I think it was a very good suggestion. As Major Gorman mentioned, we don't like to tell a doctor "You will have to give somebody an aspirin tablet or paint something with iodine, instead of merthiolate". A lot of doctors we have had on transports may be good general practictioners, but they are certainly not psychiatrists. They do not know how to handle a lot of mental cases, and especially aboard transports. That was the reason for our instructions at New York. Whether this should be included in general instructions covered by the War Department of the Chief of Transportation is what should be brought out at this meeting, and I think it has been brought out.

LT COLONEL FARR:

I would like to hear something from Seattle.

COLONEL BRECHEMIN:

You have a point there. The only thing I ever thought of putting in the instructions to the Transport Surgeons was something that they could use aboard the transport about certain procedures, in order to show the practice aboard ship. Outside of that we left everything to the practictioner. We have had quite a number of nice young fellows who took to the sea and used excellent judgement and weren't governed by very many regulations. We wrote very little, as little as we could. We wrote the professional things adaptable to the boat that were a little different from the general practice. But we had very little professional instruction.

LT COLONEL FARR:

Charleston, have you any comments?

LT COLONEL NIELSON:

I think there are certain general administrative matters included in the general record but there are still some administrative matters that are peculiar to the port, and we will either have to standardize our procedure, or else take these peculiar portions away from the instructions to the Port Surgeons.

LT COLONEL FARR:

We are, I believe, approaching some sort of an organizational standardization within the whole group of port structures. Our control divisions are apparently working toward that end, so I suspect that administrative procedures

submitted will reach some type of standardization. What it will be is a little hard to say. I would like to ask one question on the matter of these regulations. Does San Francisco have a published set of instruction, bound or otherwise?

MAJOR QUINN: Yes.

LT COLONEL FARR:
Does Seattle have a published set?

COLONEL BRECHEMIN:
We have a small published set, much smaller than anyone else.

LT COLONEL FARR:
Does Los Angeles have a published set?

LT COLONEL WHITE:
Yes sir, we have recently written a revision within the last two weeks.

LT COLONEL FARR:
Does New Orleans have a published set?

COLONEL BRADISH:
Yes, administrative regulations.

LT COLONEL FARR:
Does Charleston have a published set?

LT COLONEL NIELSON:
We do not have a published set.

LT COLONEL FARR:
Does Hampton Roads have a published set?

COLONEL [illegible]:
We had two sets - - mimeographed sets of instructions - - one is our standard set for regular transports and the other is for the small boats.

LT COLONEL FARR:
Does Boston have a published set?

MAJOR GORMAN:

We just bound ours before we came to the meeting.

LT COLONEL FARR:

I know New York has. I would like to suggest that we get copies of regulations from each of the ports. I don't imagine you have sufficient copies to leave at this time. I think they would be valuable in working up a revision of these Regulations which we are going to put out. I think the group established to do that would do well to have complete sets of these regulations which have been compiled by each Port.

Do you have any further discussion? We still have a few minutes to talk about this subject. Apparently we are coming to the idea that these are not to be extremely specific. Is there any discussion on what part you feel should be left to the discretion of the individual ports?

LT COLONEL WHITE:

I would like to bring up this matter of supply. I think it is an imposition on the Transport Surgeon to try to make a supply officer out of him. I think all that should be necessary would be for the Transport Surgeon to present a list of the supplies needed. We have an equipment list that goes on all the various sized transports. If he presents a list to the port Surgeon of any port, it should be the duty of that office to supply him with whatever is necessary. Therefore, I think you can take quite a burden from him by eliminating all of the Supply Section from these regulations. In the matter of keeping stock record accounts, I don't know that it will be necessary. It seems to me if you take a certain amount of supplies and use them at sea, or in a theater, the Transport Surgeon should not be burdened with keeping a detailed stock record account. I think the whole trend on this should be towards simplicity and to get it down in eight or ten, or twelve pages -- rather than a large booklet.

COLONEL [illegible]:

The matter of stock accounting on transports apparently differs in different ports. I know that Colonel Melton wanted his surgeons to keep after his property, and he feels that that procedure, considering the local problem, is the solution for his situation. However, there is nothing that requires Transport Surgeons to account for property. The question came up in New Orleans and we had the Finance Section

and the Auditing Section give us an opinion and they stated that it was not required for any property accounting. We carried that a little bit further however, and shipped the supplies to the transportation agent who does maintain a stock record account and in turn issues the amount of expendable supplies to the surgeon on a regular memorandum issued slip. Therefore, he has a certain amount of responsibility which keeps him aware at least of his responsibility for the property. That keeps his administrative burdens down to a minimum and doesn't go quite so far as simply shipping the material to him with no further accountability.

Now, there is one more point I would like to bring up, and that is this. These regulation -- or this directive -- covers two phases of activity. One of them is the general standard operating procedure of an administrative nature, which affects many other agencies in the Port and must be worked out on a staff conference - type basis as it affects each port, in turn, and between themselves, and as it affects the Office of the Chief of Transportation.

Now, the other feature we are dealing with here, it seems to me, comes from an entirely different angle, and that is the one of technical supervision of medical service itself, which is basically the responsibility of the Surgeon General, and in turn his representatives from the various commands. This being a technical service, therefore, I feel that these directives, with reference to professional policies, should probably come out of the Office of the Surgeon General primarily, or at least out of the various offices of the staff surgeons on the staff of the Port Commander, and those policies, insofar as necessary, can and will be integrated for the Chief of Transportation through Colonel Fitzpatrick's office. I think we are dealing with two different procedures; one, technical service, and one general administrative service, and, we should differentiate between them.

COLONEL SCHUHMANN:

Colonel Bradish, if I may say something on that, I believe it has been brought out very well this morning, as far as the professional service or the technical service goes, it should be at a minimum in those instructions. There are seven sections to this -- one of which covers the technical care of patients. I believe it has been decided that the people who work on this new instruction should eliminate detailed instructions on professional care.

I would like to say something on that supply matter which you mentioned. It is our opinion -- when I say "our" I mean the Port Surgeon's opinion -- that the men on transports are not accountable for property. War Department Circular No. 18, this year, is the one that first came out on it. It has been modified recently, this past September, I think. It covers all supplies on transports except medical. Those words are always in there "except medical". We interpret that to mean, when the transport leaves here, there is no accountability. We got an opinion from our own Judge Advocate, Water Division, and the Chief of Staff. It was decided the Surgeon would be accountable. Therefore, in this instruction, if it isn't applicable at ports in the United States, this interpretation shouldn't be in the general instruction.

We have covered two sections in my opinion. I don't know if anyone else has any remarks on these sections which should be changed. Certainly this professional care and supply has been covered and there are seven suggestions in all. Are there any further remarks or recommendations concerning the others?

MAJOR QUINN:

In the evacuation of patients, Section III, we have a different procedure than you seem to follow here. The General explained to me, you have a tie-up with the Second Service Command, which doesn't exist in our Port. How do we standardize that?

LT COLONEL SCHUHMANN:

Maybe that will be corrected.

COLONEL SCHWICHTENBERG:

I see no reason why some more or less standard procedure couldn't be adopted. In each instance, it is fundamentally the same thing. It will standardize the New War Department Circular to include hospitalization and evacuation policies, I think in that case, whatever anyone does he will have to more or less follow the same general plan, and therefore; this will also bring it to both.

COLONEL LOWRY:

The instructions that the Transport Surgeon receives about evacuation can be standardized. New York carries it beyond where the Transport Surgeon has to go but up to a certain point the Transport Surgeon can do the same thing.

COLONEL SCHWICTENBERG:

I think you are entirely correct on that but I think the reason that the organization here did that, revolved around the fact that Transport Surgeons bring patients into the port and in reading over the instructions know just exactly what is going to happen to them, and can plan their activities so that it will dove-tail in with what is going to happen ashore. I grant that maybe that isn't desirable or the general practice, but there are going to be differences. After all you don't have a Halloran Hospital down in your place or in San Francisco. And they have still a different problem in Boston compared to the one they have at San Francisco or here in New York. They have to put men on trains, you have to do the same thing. It is not possible to formulate an exact statement, but I think you hit it quite accurately when you said certain general things apply to all.

COLONEL LOWRY:

Among the general things particularly, those of us who have to evacuate ship-trains, prefer to have our rosters prepared differently. We prefer to have them prepared by classification. In other words, we prefer the mental in one class. Somewhere in there I think we could get a standardized procedure to please everyone.

LT COLONEL SCHUHMANN:

Colonel Lowry, may I make a remark along that line? We have done that at New York. We had to line them up according to classification at one time. We had evacuation by train at New York of course, and we have gotten away from that lately. We have devised a form when we have this, so they don't have to submit numerous reports; they can have on one report everything that is required. That was the intention of this and it was put in alphabetical order so that we could locate a man by name. Now, of course, we have a system of tabbing and marking our ambulances going to the hospital, which tells what type of case it is. That is done by our own personnel here at the port. But this general form that comes in and is really a transmittal of all records -- that is what it really is -- we found very satisfactory here at New York. As you say, it might not work at another place and will have to be modified to apply to all places.

COLONEL LOWRY:

It is definitely unsatisfactory for us. We have to make it all over again if a roster is submitted in that form.

LT COLONEL SCHUHMANN:

Why do you have to make it over?

COLONEL LOWRY:

Because we frequently send one classification to one hospital and another classification to another hospital.

LT COLONEL SCHUHMANN:

From one ship you send patients to different hospitals?

COLONEL LOWRY:

That's right; from the one ship we send patients to different hospitals.

LT COLONEL SCHUHMANN:

Of course, the answer to that, I do believe, and the ideal -- I am expressing my personal opinion -- is to have a debarkation hospital where all patients are processed and then shipped.

LT COLONEL FARR:

We are getting close to our time on this. I am sorry we couldn't have gotten a little more done on it. It is a subject that is going to take quite a bit longer to finish up than that which we have allotted this morning. The only way that I see to come out with a definite answer, which incidentally will not be agreeable in all respects to the majority concerned, is to set up a small committee to do the work. I think Colonel Schuhmann, if Colonel Milton is agreeable, should do a portion of the work as he has a very good background on the subject.

COLONEL MELTON: (Indicates his reply affirmatively)

LT COLONEL FARR:

I should like General De Witt to nominate some one from his port.

GENERAL DE WITT:

I nominate Major Quinn.

LT COLONEL FARR:

May Major Quinn have about a week's duty in Washington to work with Colonel Schuhmann on this?

GENERAL DE WITT:

Yes.

LT COLONEL FARR:

Colonel Melton, can you spare Colonel Schuhmann for a week?

COLONEL MELTON:

Yes.

LT COLONEL FARR:

In order to give these two officers the maximum amount of help I would like to see copies of each of your port regulations turned over to them, and in addition we should give some further discussion to this matter tomorrow. Therefore, I want each port to submit a written list of either questions or recommendations, or, if you want to submit an outline of ideas which differ from your own set of instructions, submit these tonight, so that we can use them as the foundation for a 15 or 30 minute discussion. In peacetime, we used to write up a regulation and circulate it throughout all the ports to get their comments before it was published. I recall one regulation in G-4 which took 4 months to get out on that basis and it was a relatively simple one compared to this. Therefore, we will not have time to follow such a procedure. The committee appointed will come out with a regulation that is concurred in by the Chief of Transportation and the Surgeon General. It will be based on your recommendation and will be published subject to revision within a period of, shall we say, six months. So if you have anything that you want to get into it, the thing to do is to set it up today and be sure that it is covered.

We will now have a break of about 13 or 14 minutes, reconvening at 11:00 o'clock.

(A recess was called at 10:50 A.M.)

LT COLONEL FARR:

Gentlemen. The return of the sick and wounded from overseas has been one of our largest jobs. The plans for handling that came at a time when there was very little actual activity in the Army insofar as anybody shooting anybody else. When the ASF was first organized there was set up within it an organization known as Hospitalization and Evacuation. At that time it was decided that the ASF would be responsible, of course, for the return of personnel from overseas. It was decided that there was needed in the organization an officer who could from experience handle many of the problems that come up in the movement of personnel by transport, particularly those who get sick enroute, but later the more important job of bringing back many of the sick. The field of officers was carefully surveyed and it was decided that Colonel Fitzpatrick, who had considerable experience as Transport Surgeon and who had more or less specialized in that type of medical work, was selected to come in to the ASF Headquarters to do the work. Subsequently, it was decided the evacuation operations were becoming so important in the eyes of the Chief of the ASF, and as they were principally centered in the office of the Chief of Transportation where the actual ship movements took place, that there would be a liaison officer from the Office of the Surgeon General to the Chief of Transportation. The principal part of the work would be to hold down that particular job. The development of the sea evacuation procedures has been a very difficult one because of the overseas commanders' problems involved. Colonel Fitzpatrick has worked on that job from the beginning, and he will have to give you the "hows and wherefores".

COLONEL FITZPATRICK:

SEA EVACUATION OPERATIONS

1. General DeWitt and Brother Officers. One of the inevitable by-products of this or any war has been and will be production of sick and wounded -- not only the sick and wounded resulting from disease and non-battle injuries resulting from causes similar to those that obtain in times of peace -- but also those resulting from battle injuries.

2. Of the sick and wounded occuring in our overseas forces, some recover quickly; some recover and are restorable to full duty after comparatively prolonged periods of hospitalizations; some are permanently disabled; some die. A basic question which required an answer early in the war, was, Where to treat what type of casualty. Is it better to treat sick and wounded in the theater or to bring them back to the continental United States for treatment?

3. The answer to this question -- and this is the case with many apparently purely medical questions -- has an important effect on military operations in general. Based on the decision as to where to treat

sick and wounded -- and this decision is known as an "evacuation policy" will be results affecting:

a. Availability of experienced personnel in the theater;
b. Requirements for replacements -- which requirements of course affect requirements for outbound shipping;
c. Shipping requirements for the maintenance of numbers of individuals who are not, for certain periods, productive in the military sense;
d. Requirements for fixed hospitalization within the theater, and for the personnel and supplies required for its operation -- which also affects requirements for outbound personnel and cargo shipping;
e. Requirements for facilities for the evacuation of sick and wounded from the theater to the continental United States.

4. After a considerable study, and based on previous experience, The Surgeon General's Office has concluded that the optimum evacuation policy, taking all factors into consideration, would be a so-called 120-day policy. Under such a policy, all individuals likely to be permanently disabled, likely to require hospitalization in excess of 120 days, or requiring special treatment facilities not available within the theater, are evacuated to the continental United States as soon as their physical condition permits; others are retained within the theater for treatment and restorat; or to full duty. Most overseas theaters today are operating under a 120-day evacuation policy; a few, because of special circumstances, are operating under policies ranging from 90 to 180 or more days.

5. Whatever the evacuation policy, however, it was certain that there would be sick and wounded requiring evacuation to the continental United States; and the War Department under date of 18 June 1942; charged the Commanding General, Army Service Forces with responsibility for providing for the evacuation of sick and wounded delivered to his control. The implication was that overseas commanders would provide for evacuation requirements within their commands, and for delivering evacuees to the control of the Commanding General, Army Service Forces.

6. Responsibilities for evacuation having been fixed, the question arose: what would be the requirements. This was not an easy question to answer, since the army was then operating in many areas concerning which no previous experience was available; present-day combat methods differ from World War I methods, so that casualty results could be expected to be different; and the results of any action in terms of casualties are never susceptible of precise prediction. However, based on the comprehensive studies of General Love of the Medical Department, (World War I battle casualty statistics), and estimates from The Surgeon General's Office as to the incidence of disease and non-battle injuries that might be expected within the several physical and climatic environments where our troops are stationed today, anticipated evacuation rates (factors) were

arrived at. These factors were then applied against projected troop deployments throughout the world. It was estimated that as of December 31, 1943, we would be evacuating sick and wounded to the continental U. S. at a rate of ***** per month; that as of 31 December 1944, we would be evacuating sick and wounded to the continental U. S. at a rate of a little more than ****** per month.

7. These estimates apparently are proving conservative. During September 1943, there were debarked at United States ports, approximately ****** sick and wounded evacuated by sea. It seems apparent that, assuming a realization of current plans, the estimates both for 31 December 1943 and for 31 December 1944, may be exceeded. Perhaps by the end of 1944 we will be evacuating some ****** sick and wounded per month.

8. To return to the development of current operating procedures for the evacuation of sick and wounded to the continental U. S., the responsibility, except for intra-theater evacuations and concentrations, had been placed upon the Commanding General, Army Service Forces; the requirements had been estimated as about ***** per month by the end of this year; about ****** per month by the end of 1944. There remained the problem of providing, or designating the means:

a. Shipping, with adequate hospital facilities provided thereon;
b. Medical personnel adequate for the proper care, treatment, and safety of the sick and wounded being transported; and
c. Medical equipment and supplies necessary to enable the personnel properly to perform their functions.

9. At this time (December 1942) shipping was critical. ******** ******** ****** Medical equipment and supplies were not too abundant, especially in oversea theaters; medical personnel in certain areas did not exceed needs; and the inbound movement of personnel was negligible. And the Commanding General, Army Service Forces, not the overseas commanders, had placed upon him responsibility for the care of sick and wounded once they were delivered to his control.

10. The Joint Chiefs of Staff had promulgated a policy providing that in the interest of economy of shipping, the primary means of sea evacuation would be by regularly-scheduled returning troop transports; that eventually three convention-protected hospital ships would be made available to provide for overseas areas not served by regularly-scheduled troop transports, and to supplement troop transports in areas for which they were regularly scheduled, when necessary. The Chief of Transportation was directed to provide hospital facilities on all troop transports under his control, and it was envisioned that by far the greater part of the shipping requirement would be met by the utilization of transports.

11. The question of medical supplies was met by providing that port commanders would maintain aboard each troop transport medical supplies sufficient for the care and treatment of sick and wounded arising en route during the outbound voyage and for the care and treatment of a number of sick and wounded equal to one-fourth the troop capacity of the ship during the inbound voyage.

12. The provision of medical personnel to care for patients evacuated to the continental US presented a problem more difficult of solution. The goal was to provide adequate personnel for the care of the sick and wounded and at the same time conserve shipping space. Because shipping schedules were unpredictable, it was never certain that a given ship would or would not bring back patients. Not more than one-third of returning transports brought back any considerable number of patients. Therefore, if personnel adequate for the care of a number of patients equal to one-fourth the troop capacity of the transport were permanently stationed aboard all transports, there would have resulted a considerable loss of personnel shipping space.

13. Nor was it possible to depend on medical personnel returning from overseas to the continental United States. At that time the numbers of such personnel was wholly inadequate to provide the personnel required for the care of such sick and wounded.

14. It was therefore considered desirable to establish in each overseas theater pools of organizations under the ultimate control of the Commanding General, Army Service Forces (through the Chief of Transportation) and available to the overseas commander, to be embarked on returning transports when needed. It was decided to use regularly organized units rather than individuals in order to provide ease of administrative control.

15. The foregoing is essentially the system of sea evacuation operations under which requirements are being met today. The system is not perfect; it is certainly not the only method that could be employed to do the job satisfactorily. But this system is working satisfactorily. It is not considered desirable to materially modify it until by actual experimentation and trial another system can be demonstrated to be adequate. Recent developments however have made minor modifications of this present standard operating procedure inevitable:

16. In the spring of this year, the shipping situation became more favorable; it became more apparent that the enemy would respect convention-protected hospital ships. A recommendation originating with The Surgeon General that convention-protected hospital ships be considered the normal means of evacuating the helpless fraction of the sick and wounded, was presented to the Joint Chiefs of Staff; and there have been authorized a total of 24 hospital ships of which there are now 3 in operation, and 11 under construction. It is anticipated that in the near future the remaining 10 ships will be selected for conversion, so that the whole program will have been completed well ahead of schedule.

17. For various reasons, it is contemplated that the numbers of duty personnel returning for various reasons will materially increase; included in this returning personnel will be the usual proportion of medical personnel. It is imperative that full use be made of their services while enroute back to the continental United States, both because of the increasingly critical shortage of medical officers (doctors) and also in order to avoid unnecessary wastage of outbound personnel shipping space.

18. For the foregoing reasons, there will be shortly processed a new directive for sea evacuation operations. It is difficult to predict the details of this directive but in general it will provide:

a. That convention-protected hospital ships will normally be utilized for the evacuation of the so-called "helpless fraction" of the sick and wounded to the continental United States;

b. That hospital ships will be under the control of the Chief of Transportation, will not be assigned to a theater, are meant primarily for the evacuation of of patients from overseas to the continental U. S.; that they may be concentrated temporarily for the support of an amphibious operation; that they may be utilized for intra-theater evacuation on a temporary attachment basis; that they may be so routed as to assist in intra-theater evacuation without seriously interfering with their primary function of returning patients to the continental United States;

c. That the remainder of patients (approximately 60% will continue to be returned on troop transports, to be cared for preferably by medical personnel returning for other reasons if available; otherwise by ships' platoons; or, if other means are not available, by personnel furnished by the overseas commander for this specific purpose.

d. That because of the fact that convention-protected hospital ships may require to be concentrated for the support of an amphibious operation, or may suddenly cease being used because of enemy action (Pacific especially) it will be necessary to be prepared for a sudden return to full utilization of regularly-scheduled troop transports, with returning personnel and/or platoons provided for care en route;

e. That the reserve of platoons necessitated by the consideration that convention-protected hospital ships cannot be wholly and continuously relied upon, will be utilized:

(1) In part, to man some of the large number of new troop transports that will be available in the near future; and

(2) By attachment to port installations, and nearby service command installations (particularly to cover rail movements of patients). This is already being done by some ports, with mutual satisfaction.

f. In recognition of the fact that the composition of any group of patients being evacuated by troop transport may vary within wide limits, there will be attached to the new directive a table to serve as a guide to overseas commanders in the use of platoons or other personnel for covering return of patients; and it is thought that this will enhance efficient use of such personnel, and delay or perhaps eliminate any necessity for a material augmentation of the requirement for platoons; that it may permit a reduction in platoons even in the face of increasing requirements for evacuation.

19. A directive to ports will modify current responsibilities. One thinks particularly of the anomaly that presently attempts to hold certain ports responsible for evacuation from given areas when they have no knowledge and certainly no control over the means for discharging that responsibility.

20. In general it is thought that the current procedure for the return of sick and wounded to the continental U.S., with such minor modifications as changing conditions require, will not only meet requirements during the war, but will also meet post-armistice requirements when, for a few months, it can be anticipated that requirements for such evacuations will double or triple.

21. One possibility upon which I have not touched, is that of an increasing utilization of air transport for the evacuation of patients, not only within theaters, but also for the evacuation of sick and wounded from overseas to the continental U.S. Just what part this facility will play in the future operations, just how extensive the use of air transport will be, is not predictable except that it is likely to be quite extensive. The Army Air Forces are working on this problem, and Colonel Schwichtenberg may have some remarks to make about the possibilities. Are there any questions? (No questions were asked).

LT COLONEL FARR:

Now, this was a very thorough discussion, but I don't think that it was so thorough that we can't ask questions on it.

COLONEL BRECHEMIN:

What is the capacity of the 24 hospital ships authorized?

LT COLONEL FITZPATRICK:

Each of the 24 ships has an average capacity of five hundred patients and an average speed of approximately 12 knots; the ship's capacity applied to that average speed gives you a certain probably patient lift which is sufficient to meet 40% of the total requirements as previously estimated, and as they are estimated today.

BRIG GENERAL DE WITT:

We are training now in the staging area in Camp Stoneman four hospital ship companies. Sometime ago, when those units were activated, the activating order stated that the Commanding Officers would be furnished by the Surgeon General. Up to the present time some of those units have been there for two months without any Commanding Officers. It seems to me, it is rather important that those men get there in time to familiarize themselves with their units. I would like to ask Colonel Padan if he can give any information relative to that.

LT COLONEL PADAN:

General, these men have been selected in accordance with the directive that came out. It said that these hospital platoons would be activated on a certain day - we'll say it was the 10th of the month, and we got the directive about twenty days after the activation date; that very frequently happens. These Commanding Officers have been selected and all of them have been placed on orders. I understand that one man was granted leave somewhere. I don't know where it was granted, but he never showed up. The first two individuals we selected for that were Regular Army men. Upon selection for that duty, they came in with a pitiful howl - they didn't like a boat - they would get seasick. One of them said he had nothing but a fishing trip that came close to any sea experience and he has been seasick, and everytime he had gone overseas, he had been sick - he didn't want any part of it. We didn't want a man with that kind of attitude, so we got a couple of other men and one of them gave the same story. We have to get these men cleared. There are still four men ordered to go and one of them, the last one, states that he despises and hates ships and is going to get sick. We had told him that after he had been at the port a reasonable length of time and submitted a request through channels, we would try to replace him. We feel that we should be very careful in selecting Commanding Officers for these ships. Everytime we get a man that would fit the bill he comes in with this story. Are you going to put a man with that attitude aboard ship? You may just as well not put him on. They are under orders and I know one of them has been granted a rather extensive leave.

BRIG GENERAL DE WITT:

One reason why I ask the question is that I have one officer, a Captain now, who desires to reach the grade of Lieutenant Colonel.

LT COLONEL PADAN:

We can't make him a Lt. Colonel, but we would rather see that he is well qualified for this assignment. We would like to know the names of any men that you have who are fit for this job. We have people who have requested this duty. We have one man who is exceptionally well qualified for this detail. It so happens that I would like him, an ideal man from all aspects, but the Military Intelligence Division says that he must remain in a certain spot, so that eliminates him. It seems like all the others we select, for some reason don't want to go on there.

BRIGADIER GENERAL DE WITT:

I have one man who is not worried at all and who wants to go on that particular duty, so it's a hard proposition.

LT. COLONEL PADAN:

Colonel Fitzpatrick has a plan, I think to revise downward the reorganization of some of the larger hospital ship platoons - anyhow, the first original of the company ship platoon - some of those will be reorganized to provide porsonnel for hospital ships.

BRIGADIER GENERAL DE WITT:

One other question I would like to ask is about the equipment of these ships. Will they be equipped at the port at which the conversion is made or at the first port of call so far as that port is concerned?

LT. COLONEL FITZPATRICK:

I think that will depend upon whether the conversion is made at a port under the Chief of Transporation or at a port not under the control of the Chief of Transportation.

LT. COLONEL FARR:

The fixed equipment will be part of the conversion contract. You are referring to the supplies. They have fixed equipment here and ship equipment which is sterilized and ready to go.

BRIGADIER GENERAL DE WITT:

I suppose it is converted here in New York and then transferred to the Pacific. Will the equipment be put on here or at the port of departure?

LT COLONEL FARR:

It will be put on at the Port of Departure. (To Colonel Schwichtenberg) Would you like to say something about air evacuation?

COLONEL SCHWICHTENBERG:

Just a few words on air evacuation. We know that it is a good deal faster than the rest, but it has one advantage entirely apart from its speed and relatively speaking from the number of patients we move,

you require far fewer medical personnel to handle them. Medical personnel is getting scarce and that is another desirable way of conserving them. Many of you know and some of you have heard rumors of large equipment that is coming out. I am not at liberty to tell what some of the larger equipment will hold, but it may be that some of our evacuation problems may be materially modified by air evacuation. That, of course, will only change some of our problems because while now we have our patients coming into the ports, in that event they will come into air fields somewhere. As I look over our facilities at the air force stations, very few of them are equipped to handle patients in the numbers that may well be brought back in routes of transport planes and there are modifications of levy equipment that is being made available. The problems that you have as Port Surgeon will then be spread from the ports to a large number of places, and as I say, it will not diminish the overall problem. It will probably change its complexion here and there and that's about all that I can tell you.

LT COLONEL FARR:

Have you any further questions on this matter of evacuation organizations and hospital ships and what not?

COLONEL MELTON:

I think the suggestion that the Port Surgeons could present the name of a specially qualified medical officer who had experience on our ordinary transports should be given a great deal of consideration. We can furnish you some excellent men that we know have been excellent on board the ships, but we want them replaced. Remember that. (Laughter) Our liberality does not go that far. (Laughter).

LT COLONEL PADAN:

We will replace them numerically.

COLONEL MELTON:

I have the statistics of some of our ships that are already converted and several others that are being converted. Are there any objections about telling them the approximate capacity of those?

LT COLONEL FARR:

That's all right.

COLONEL MELTON:

Well the Acadia is already converted, and has 604 and the Seminole has 442, and the Shamrock 547 capacity. They are the three ships in operation at New York. Now we have in process for reconditioning hospital ships one with 406, and one approximately with 640, and one 500, one 250, one 700, and one 800. Those are the ships in process of being reconditioned as hospital ships.

LT. COLONEL FARR:

This manner of submitting names, do you want the ports to submit directly to you the names of personnel that would be capable to command hospital ships? Would you have each Port Surgeon submit such a list?

LT. COLONEL PADAN:

I would and then we would take it up and consider the clearance. We would take it up with the COT and then let it go back to the port. We would just like to have a few who are exceptionally qualified.

LT. COLONEL FARR:

It will be done. Now on this movement of hospital ships from the east coast that we are going to effect this month, I have hopes of our hospital ships making their port of call Charleston. We had a little difficulty getting one of them to go in there, but maybe with a little bit more training we could get them to find the harbor. (Laughter) Are there any further questions on harbor ships and evacuations? Well, we are about ten minutes ahead of schedule which is not serious or critical, but if there is any further discussion, let's have it.

LT. COLONEL FITZPATRICK:

I would like to make just one suggestion on the matter of those names of officers to be turned in to Colonel Padan as recommended for being C.O.s of hospital ships and that is this: Inasmuch as those officers are going to function in a duel capacity, as doctor and transport commander, extreme care must be taken to insure that the officers so selected are not only efficient as medical men, but also that they are capable of exercising command functions in a creditable manner.

LT COLONEL FARR:

That is a very important point. We have had some not too fortunate experiences with some of our very capable surgeons in the matter of administration, and

speaking of hospital ships too - administratively - they did not come up to standards and very nearly got us into some rather serious trouble, because of that. Another thing on these commanding officers. General De Witt has indicated that he thinks they should assemble with their unit from a purely transportation standpoint as soon as possible because as soon as that outfit is assigned to a specific vessel, either the C.O. or some one designated by him will be ordered to the port at which the vessel is being converted to help on the details of the conversion. As the drawings that are made up are only general, and the many minor changes that have to be made are made on the spot, the C.O. or someone else of equal ability in his organization should work ahead with the conversion of that ship. He should have a chance to be with his unit before he goes ahead and therefore I would like to urge that they get him out of there and get him out fast, leave or no leave.

LT COLONEL PADAN:

How is our table on hospital ship complement coming along? Do you know what it is Colonel Fitzpatrick?

LT COLONEL FITZPATRICK:

That will be the subject of a conference. When the conference will be held, I don't know.

LT COLONEL PADAN:

You should know that a new table for hospital ships is being proposed and a radically changed and revised table will result. I don't know how it will end up or when, but it is coming.

MAJOR A. P. FULTON:

What is the percentage of mental patients expected to be returned? Bringing back any shipload, what is the maximum percentage of mental cases to be expected?

LT COLONEL FARR:

You mean the percentage that can be placed on board?

MAJOR A. P. FULTON:

Yes, the percentage of accommodations you could have on board.

LT COLONEL FITZPATRICK:

There is a new instruction which has recently gone out from the Water Division of the COT office, which provides minimum accommodations for mental patients - the so-called security accommodation type equal I think, to 4½% of the total trip capacity of the ship in question.

MAJOR FULTON:

That isn't exactly what I have in mind - say a hospital ship with a capacity of 500, what is the maximum percentage which we might expect to have available for evacuating mental cases.

LT COLONEL FITZPATRICK:

Approximately 50%.

MAJOR FULTON:

Our present conversion has been at least 30% or in that region. In other words, we are about 20% short on existing ships.

LT COLONEL FITZPATRICK:

That's right and in the last few days, a recommendation has been sent from Colonel Farr's office to the S.G.'s office recommending that a change be made to provide for a maximum of 50% of this basis - that between 20 and 25% of the total patients arriving from overseas are mental patients requiring aboard ship, not on land, security accommodations. Now since all that type of patients is included in the 40% which is supposed to have been taken care of by hospital ships, that is equal then to ⅝ of the 40% which would require about 50% of your accommodations on hospital ships to be suitable for mental patients. It is still necessary, however, to provide spaces on troop transports because of a question of the possibility that hospital ships may be withdrawn either temporarily or permanently for various reasons from a given area.

BRIGADIER GENERAL DE WITT:

In connection with the evacuation of mental patients, it might be of interest to know that shortly before leaving San Francisco, I had a long conference with officers who had spent a long period of time in the Southwest Pacific and a shorter time in the South Pacific. I was told that the Surgeons in the various theaters out there were very much concerned over the accommodations of mental patients and that they were accumulating a much larger number than we could evacuate without existing facilities. This particular officer who was

pretty thoroughly familiar with the whole system of sea evacuation, has gone so far as to devise some scheme by which they would have portable accommodations. He brought back a sample of a airplane mat, on which to have these things so that they can fix them into the hulls of a ship, and bring back these patients in very large numbers. I think that thing is coming up shortly - why we should not provide a great many more accommodations than are provided at the present time.

LT COLONEL FITZPATRICK:

That very same question did come up in Washington. It was received from the Southwest Pacific area and as a result of their request, a directive has gone out from the Water Division of the C of T which increases facilities aboard troop transports for the return of mental patients by an amount equal to three percent of the troop capacity of each ship. It is for that same reason, that the medical capacity on hospital ships is being increased.

BRIG GENERAL DE WITT:

It is 4½%. These directives have been out for some time.

LT COLONEL FARR:

I think you are thinking of the total hospital capacity. This is to be mental capacity.

BRIG GENERAL DE WITT:

Of course, mental.

CAPTAIN YOUNG:

Speaking about the estimate of the percentage of mental cases which we may expect in the future, do you think in the opinion of the Surgeon General's office, that this percentage will be maintained or increased, I mean maintained at its present level or increased? It was my understanding in talking with various people concerning the classification of mental cases, that many of these boys were sent overseas in the first part of war who had not been thoroughly understood, shall we say, as to their mental capacities or mental or moral fibre so that this particular subject then has been taken up in greater detail, with the men whom we are sending over in our present group of troops. What I really want to bring out is that the examination of those going over today is carried out more thoroughly so that we may expect that the number of mental cases will not be as great in the future.

LT COLONEL FITZPATRICK:

That question as far as I know personally is rather unpredictable, the neuropsyhiaric branch of S. G's office will perhaps be able to give a more precise answer. I would guess that any decrease in the incidence of mental cases among overseas troops which results from a better screening of troops outbound, will be neutralized by an increase in the incidence of mental cases resulting from the factors of combat activity and other unpleasantness overseas.

COLONEL MILTON:

I wanted to ask Colonel Fitzpatrick, he brought out in his paper that we should have on our transports, supplies sufficient to evacuate one-fourth of the troop carrying capacity in addition to what we put on here for the outgoing voyage. Now, we have done that, although we had an investigation a short time ago, in which it was said there were not enough suppliesaboard ship - and I think that is not borne out by the facts in the case. Now we just recently got a wire that we put a four month supply on each ship. Does that four month supply include the extra supplies that we already have on these ships? We find we have a great deal of trouble in getting space to store these supplies. We have an argument every time with the ATS that they don't have enough space. Now, if we put four month supply on board and we have been putting approximately four months supply aboard in addition to that, is that to be continued - are we to continue with that?

LT COLONEL FITZPATRICK:

That requirement of four months supplies applies only to a specific theater. It is temporary at the specific request of the overseas theatre commander. I would suggest that the supplies necessary for the care of the number of patients be limited to 25% of the troop capacity in question and to be included in the four month supplies, and that the four month supplies not be in addition to the supplies required for patients equal to 25% of the troop carrying capacity of the vessel.

LT COLONEL FARR:

I believe that is the intent of the overseas commander in his request. We will adjourn for a little lunch and will return this afternoon at 1:30.

LT COLONEL FARR:

Our discussions so far have been on facts rather than on anything that we are trying to uncover that is new. We are by requirement, as we have discussed before, going to have to load transports rather heavily. They are crowded, uncomfortably crowded, in many cases. But it is part of the risk that we have to go through. Now it is surprising sometimes what small things change the trend of the war. It may be that some of the advanced things that the Surgeon General has done and will do, will further change the trend or the picture of the War. We have as a speaker this afternoon an officer who is going to bring up something that is quite new to all of us. He is Colonel Bayne-Jones, from the Surgeon General's Office, who is Assistant Director of the Preventive Medicine Division.

COLONEL BAYNE-JONES:

Gentlemen. Being the first speaker in the group who came up from the Preventive Medicine Division of the Surgeon General's Office, I want to say for all of us how much we appreciate the invitation to be here, and also to express the real feeling, the great satisfaction and sense of privilege we have in being close to Port Surgeons and Ship Surgeons, and the men who are handling epidemilogical problems at a focus. You get it on the ships, in the staging areas, at the ports and often in a very concentrated form when things have to be handled quickly and expertly. From our talks last year there has developed an epidemilogical point of view and mutual understanding of most kinds of theater problems.

We take things more or less as they have to be taken in dealing with crowded conditions that can't be relieved by separating people into more space, and as I say, trying to revise means of focus. What I have to tell you about today is in the nature of progress reports. I have not a practical apparatus to propose to put on all ships on a movement to sterilize the air in troop quarters at least, but a commission in airborne infections under the Epidemilogical Board, a large civilian board. The commission has been working constantly at Chanute Field and other places to try to devise means of sterilizing the air; thereby, cut down or remove the agent which produces the acute respiratory diseases with which you are mostly concerned.

The chief of the diseases that you have to deal with in these troops on ships, as we saw it last year, was really acute infection of the upper respiratory tract, notably common cold, possibly influenza if it comes on, streptococcal infec-

tions, tonsillitis, and we can include in this group of respiratory infections, meningococcal infections. These infections give us most trouble in certain seasons of the year although they are prevalent in various times of the year. But the season of greatest anxiety and difficulty, I should say, would be from December until into April. These diseases occur more frequently under conditions in which troops are crowded, and occur under the living conditions that men have on the transports that you are handling.

The modes of spread of these diseases are familiar to us. By knowing those modes of spread, and I think by thinking about them again we can get on to devising some means of control. Infections are spread by contact and by droplets from coughing and sneezing; I would say by air and very fine particles that may be in the air carrying virus and bacteria. We feel quite sure that they may be spread by dust, but studies indicate that pathogenic organisms can be gotten up off the floors and out of dusty air; and lately a great deal of attention from our commission has been focused on the content of blankets and covering of beds and things, in terms of the pathogenic organisms, notably streptococci. Last year when this problem was studied it seemed pretty clear that you had two phases of it to deal with. One that concerned the Ship Surgeon was the outbreak of acute respiratory diseases on a ship a few days after it left the port.

Now the men bringing that infection aboard which was probably incubated in the staging areas, and in incubation periods when they came on ship. There is not a great deal that you can do as a Port Surgeon, at least as a Ship Surgeon, to control the men that come aboard infected in that manner. We heard from General Hawley last year, particularly that what troubled him was the acute respiratory infections arising in troops after they landed. The figures have shown that there would be an outbreak on ship and then a subsidence, and then an outbreak of respiratory diseases among them, after they were ashore on the other side, undoubtedly indicating that they had infections spread to them on the ship. Those are two main troubles, and focusing the fact to what may be done on board ship will probably lead to relief to some extent of the early stages of infection, and perhaps lead to control and prevention of infection to men on the ship.

There are two main methods of approach to this problem, granted that we have a crowded condition that we can't correct by separating the men: one is by giving the men drugs that were supposedly anti-bacterial or help them to get over this bacteria; and the other is to do things to the air that they breath and the articles that they are most intimately in contact with, to reduce the virus and bacteria of these fine

particles. The use of drugs to control the respiratory infections means the use of sulfanilamides, notably a sulfathiazole. There is still a debate going on as to whether you can control the ordinary respiratory diseases by giving doses of sulfadiazine to soldiers when we got interested last year with the reports that came from the Navy Doctor Rivers and his group. He found that by giving as little as a half gram of sulfadiazine at various intervals sometimes he had some periods of one a day, sometimes once a week, to men in his pier where theNavy were quartered the incidence of tonsillitis and scarlet fever dropped quite substantially. At the same time, however, his latest paper showed that the incidence of a streptococcus carrier was not produced. However, I believe that might come out in the discussion. There have been actual trials at some of the ports in which sulfadazine had been used, and the incidence of scarlet fever and some of the sore throats have been reduced. I think more experimentation might well be done along that line, keeping good record and knowing that this small dose will not provide any troublesome reaction.

The most notable result of last year's studies in camps was the destroying effect of sulfathiazole on the reduction of meningococcus carriers and the stopping of outbreaks of meningitis. We have on the basis of those studies - Circular No. 170, dated September 30, issued by the Inspector General, which only came out a couple of days ago. I thought I would mention it to add a little more to the background. It is recommended in this Circular letter that a single dose of only two drams of sulfadiazine be administered by mouth to new recruits, say within the first six weeks of their entry into Service. It seems perfectly phenomenal that so small a dose of sulfadiazine would do anything, but in camps where carrier rates of meningococcus were 30 percent and even higher and in some cases up to 70 percent, these cases were reduced to carrier rate of zero. Thereafter, it stayed down for some reason not yet understood. It stayed very low for three weeks, rose slightly in the next three weeks, and Colonel Kuhn has recently reported that somewhere more than two months after doses were given, and such a small dosage, few cases developed. Moreover, where it was possible to divide a division in half and free to keep the other half in control, practically no cases occurred in the treated group and cases continued in the other. Some of this work was done in the meningococcal infections last year, and there are some questions perhaps that may have been on the downslope when some of this work was done. But the mass of evidence is thoroughly in back of this recommendation that comes out in Circular letter No. 170 that sulfathiazole be used for the control of meningococcus.

I should think it would be used as we say it in here in small groups of soldiers under crowded conditions, as on a troop transport. This new work takes away practically all the terror that we have had meningococcal infections in the past, and gives you a means of control that is sustaining. For the blankets and the floor covering on floors, some extremely interesting new work is coming along indicating that you can treat those new materials with one of these glycols plus other wetting agents with some urea in the mixture.. It is amusing to see some of the bacterial counts that have been used in some of the posts in the Army last winter. During the next winter it is extraordinary how that count has been greatly reduced by application of some of these new methods by the sterilization of the air.

As I say I have been making progress reports of many of these new methods. For the sterilization of the air, I am quite sure in due time the use of ultraviolet light and the use of glycol vapors will swing to the side of the glycol vapor action. Experimentation is going to the extent of both these agents. It has always seemed to me that the difficulty of these ultraviolet lights is that you are bound to eliminate a great space. It is not likely that you want to sterilize by the use of ultraviolet light. In addition it may not be free from irritating effects; on the other hand glycol, whose vapors are extraordinarily bactericidal, may kill bacteria and they kill virus in the air with substantial rapidity. And these two substances, propylene glycol and triethylene glycol, when concentrated one part of two hundred million triethylene and one part of five hundred million propylene will sterilize the air very quickly..

Last year we talked, Colonel Melton and others, about the use of propylene glycol on ships. We found that propylene glycol had a slight fire hazard. In vapors it is not inflammable but where running down the window pane it could be lighted by a match or a spark. Trial showed on the other hand that it is not so inflammable and a relatively little fire hazard. Last year the apparatus for vaporizing propylene glycol and triethylene glycol was tank heated by electrical heaters, and vapor blown off by tanks with the intention of introducing it into the ventilating system of the ship. What we are leading to know and what we have designed here I am sorry I can't pass around, or show to you in any detail. It is really a tank (holding up book from stage) of triethylene glycol surrounded by a steam jacket that can be used on a ship. Even with a pressure of 30 lbs in this line triethylene glycol is heated by that and steam is bubbled through an inner compartment and the intention is to introduce that vapor into the ventilating system of a ship. The problem yet to be solved is on actual trial. This has been put under conditions in which the rocking and swinging of a ship

do not upset and splash the material all around, so that it is lost or mixed up in improper ways. It has no moving parts, it hasn't any sparks or any motors. By the way, the concentration of glycol coming out can be so adjusted that you can get anything from almost any amount vaporized that you wanted, according to the size of the amount, in handling the apparatus. The other part we all need to understand is the factor of concentration of the vapor. It acts only in the range of humidities between about 30 and 60 percents, best in the region of 35, humidity of 35. Therefore, it is necessary to control humidity in the ship as well as to control the concentration of vapor.

One of the things I hoped might come out in the discussion is whether you have humidifier things on ships on the northern trip in winter; and if not would it be possible for us to supply surgeons with Gycrometers, a thing that begins pretty soon to take readings, so that we might know what the northern run in the winter time may be and what humidities there might be on different parts of the ship. The other thing this might lead to would be a trial installation of this apparatus on a ship permanently in port, gradually working it up to a time when one might feel relatively certain where it would go and work practically on a voyage. At that time we would like to ask if some of our civilian consultants, who are experts after years of study, might join up with a team of ship personnel and get the trials that would be necessary to put this before you in a convincing way.

I am bringing you, as I say, some definite progress on the use of sulphadiazine, particularly on the control of meningitis, and a fairly definite statement that we feel we may be on the way; that we have an apparatus for glycol vaporization that may be worth your consideration, on ship.

LT COLONEL FARR:

Any questions you would like to ask? Colonel Bayne-Jones brought up some very interesting points there. How soon would you want to do some installing?

COLONEL BAYNE-JONES:

Well, I should say within the next month or month and one-half.

LT COLONEL FARR:

Any further comments on this?

LT COLONEL FARR:

What are the possibilities of such a procedure?

LT COLONEL FEISTEL:

You probably would need a dozen of those machines on a ship. If an apparatus like that could be used with an electric squirt gun, I think this apparatus might be a little more practicable for the ship. Now on most of these ships the vessels themselves are rather old and the ducts through which the spray would have to come are numerous. You would need quite a few of these things before you would be able to effectively work it.

COLONEL BAYNE-JONES:

I am wondering whether or not we could use the ventilating system.

LT COLONEL FEISTEL:

The newer type ships can, but in some of those old ones it would be difficult to rig one of these things up.

COLONEL BAYNE-JONES:

The Colonel expresses a conception which is interesting to me but is turned down by experts. That is the conception of spraying a ship around as you would from a bomb in compartments. That would solve the problem somewhat. On the other hand, we ought to be able to keep a concentration in a super-saturated atmosphere right along. I am not sure. I doubt whether just a periodic spraying would do the job. The air would soon be filled again with the bacterial viruses from the men who are in the room.

LT COLONEL FARR:

I think what Colonel Feistel had in mind is some kind of spraying system in the ducts that could be spraying constantly. Now I gather that is a liquid that has to be heated and vaporizes from the liquid.

COLONEL BAYNE-JONES:

One successful experiment was done in Philadelphia in a ward, and in a school, where they let the glycol vapor drop down on a hot soldering iron and then it was blown around the room with an electric fan.

LT COLONEL NEILSON:

I think it would be a great thing to put this method if it were perfected, in a staging area because all staging areas have now **********square feet per man.

COLONEL BAYNE-JONES:

Trying to use the glycol vapor in the staging areas is difficult on account of the humified atmosphere. The barracks don't lend themselves to air conditioning. You have open windows, open doors, and the heating system all makes it extremely difficult to get the actual conditions you would have to have in a staging area.

COLONEL LOWRY:

Have these electric humidifiers been on the market many years? I am thinking of a little pot-like arrangement with an electric heating element.

COLONEL BAYNE-JONES:

For humidifying the room they may be used.

COLONEL LOWRY:

You are normally supposed to use water in these things. They have a fan in them. They operate nicely.

COLONEL BAYNE-JONES:

I don't know whether they have actually used one of those things. The electric heated vaporizer which was devised last year was on the same principle, only you have to have a separate humidifying system. The relation between the glycol in the water vapor is something like one part of glycol in three thousand parts of water, so that they don't go from the electric humidifier very well.

COLONEL FARR:

Who is here from the Water Division?

MR. MURPHY:

I have just come in, sir, and I think we can supply you with information on the humidity condition on the Atlantic. We have ships at present with air conditioning with spaces such as mess rooms in which experiments might be carried out.

COLONEL BAYNE-JONES: You have the data ready?

MR. MURPHY:

We have the data on humidity and temperature and we have what we call a thermo system.

COLONEL BAYNE-JONES:

As a matter of fact triettylene glycol has been used satisfactorily. It is part of the air conditioning system. You can actually use it to take some of the vapor out.

MR. MURPHY:

I think probably the problem is to keep the balance between the two.

LT COLONEL FARR:

Would it be possible for your to give those figures to Colonel Bayne-Jones on humidities?

MR. MURPHY: Yes, sir.

LT COLONEL FARR:

Major Fulton, do you have any information on humidities?

MAJOR FULTON:

No I have none in mind. There are no two ships alike. The heating is a mixture of direct radiation and cold air passing through coils and then on into the various compartments as heated air. In addition we are constantly installing cold air ventilation so that each ship would have to be a subject of study for that particular installation, but as far as humidity goes, I have no figures on that.

COLONEL MELTON:

I would like to make a remark on sulfadiazine. Late last winter I found out that Dr. Rivers had been doing this experiment we are talking about in the control of scarlet fever. At that time we were having quite a number of cases of scarlet fever in the task force units in our staging

areas. I came back and we issued directives to our staging area surgeons in all units in which scarlet fever occurred. They were immediately to give each member of their units five tenths gram of sulfadiazine. They were to follow this up day and night. They were to make the Dick Test. They were to discontinue at the end of twelve days, on the ones that were negative. We got excellent results in every case. Very few cases of scarlet fever developed and it disappeared as though by magic. I am telling you what our experience has been here. I think it is worth trying.

MAJOR GORMAN:

I would like to ask Colonel Bayne-Jones what his experience has been in influenza with sulfa drugs.

COLONEL BAYNE-JONES:

I haven't had any experience with sulpha drugs in influenza. There haven't been enough influenza in troops this year to make a trial. The general impression is it is of no value on the influenza virus. We haven't had a chance to try it this year.

LT COLONEL FARR:

I think the subjects that Colonel Bayne-Jones brought up are some of the most important things we can be thinking about. In other words, prevention of some of these air-borne diseases. I believe that it would be very well if we could have some of our port personnel work with you, Colonel, on the practical aspect of putting them on board ship. Now, for your convenience, should we use an East Coast port as a guinea pig or would you like to have an East Coast and a West Coast port working on it.

COLONEL BAYNE-JONES:

I would say an East Coast port because the center of apparatus manufacture is in the East. The main groups of people are most accessible in the East. We are mostly interested in the eastern run.

LT COLONEL FARR:

We are coming into winter and it is time that if we are going to do something, we should be doing it. Colonel Feistel, I would like to have the facilities of your place; I would like to have the facilities of the New York Port. I would like to have the Water Division at Washington

get in on this, and we will put everything behind it to give you a start on this thing with a view towards getting an experimental ship out as soon as possible.

LT COLONEL FEISTEL:

I can take Colonel Bayne-Jones with me and start on it.

COLONEL BAYNE-JONES:

I have to go back tonight.

LT COLONEL FARR:

We will arrange to have you start at the first opportunity convenient to you which may be some time this week.

COLONEL BAYNE-JONES:

This comes pretty fast, but I would like to have the means to go ahead with it.

LT COLONEL FARR:

Colonel Fitzpatrick will be the local correlator in the Chief of Transportation and will see to it that you get started on it promptly and will see that you get something done. I believe we should have a representative of Colonel Melton himself in on this, not only from the standpoint of glycol distribution, but also on these other medical practices which you and he have been working on. Does anyone have anything else that he would like to ask Colonel Bayne-Jones?

COLONEL MELTON:

I would like to ask Colonel Bayne-Jones when Dr. Robinson was here when we were trying this experiment last year, he spoke then of soaking sheets in this solution and hanging them up. At that time he hadn't developed fully what the effect was going to be on upright individuals like man. He was trying experiments then on monkeys and rats doing autopsies on them. Do you know what the latest results on that have been?

COLONEL BAYNE-JONES:

Triettiylene glycol vapor doesn't hurt monkeys and rats. We know its use in air conditioning some large buildings in New York, particularly when used it and nobody knew it was there.

LT COLONEL FARR:

Thank you, Colonel. Our ports whether far or near are located near large cities which have rather high venereal rates. For reasons psychological or otherwise there breaks out on transports cases somewhat heavier than you may find in normal well-policed camps. The problem which results is quite a headache not only to the Transport Surgeon but to the surgeon on the other side after their arrival. It causes concern to the Surgeon General and to the Chief of Transportation. We have Lt Colonel T. B. Turner, Chief of the Venereal Disease Control Branch of the Preventive Medicine Division of the Surgeon General's Office here this afternoon who will discuss this problem.

LT COLONEL TURNER:

Colonel Farr and gentlemen. During the past six months the venereal disease rates have showed a favorable trend with between 25 and 30 cases per thousand. We have administrative problems really out of proportion to the actual number of cases. It has even gotten mixed up in the question of Anglo-American relationships during the past few weeks so that there is a continuous problem. Some months ago we became excited about the higher rates at the port of embarkation and began to look into the problem. It was immediately apparent that these high rates do not actually reflect conditions at the ports. It was simply a reflection of what was going on in other areas of the country - the large number of troops funneling through these ports. Our survey did reveal that there were problems involved. I would like to sketch very briefly what we regard as some of the problems and then ask a few specific questions that I hope can be further discussed by this group. This will help us or help this group in developing an overall policy. There are two major aspects. One is the preventive problem - that is the protection of troops while they are in the staging areas and ports. When these troops arrive it is presumed that they have been indoctrinated and sufficiently educated and instructed in methods of protecting themselves, so I think there is not much that we can do about that. It comes down in our opinion largely to a question of providing prophylactics. It seems that station prophylactics will always have a very limited usefulness. For example, men who come in here for a short time in New York, it is almost impossible to instruct them adequately where stations are here and see that those stations are accessible to them. It is almost impossible to do that. So the first question I would like to put to the conference group is with respect to the practicability or the advisability of making individual prophylactic packages available free to soldiers in staging areas. As you know,

in this country we have individual packets which are supposed to be kept in unit day rooms. They are supposed to be sold or bought with the unit funds and resold to the soldiers or given away. As I understand it, we have been going over this whole thing with Colonel Melton and some of the other Port Surgeons. Most of these units, as I understand it, don't have funds and the system now in effect abroad is that if a unit does not have unit funds the medical officers are authorized to issue them without cost. Now the question is, should that policy be put into effect in staging areas. I am of the opinion that it should. Secondly, there is the question of sulfathiazole prophylactics. I don't believe that that has been developed at these staging areas to the extent that it might be. Sulfathiazole in doses of two grams, either divided into two doses of one gram or one single dose appears to prevent gonorrhea and the problem comes then to an administrative one. Can sulfathiazole be administered to those soldiers that need it rather than as a mass process. We don't believe it is justifiable to give it too freely but if there is some administrative mechanism whereby the man coming in can be picked out, that is the man that needs the prophylactics, we believe that it is an important aspect of the program. Now the second feature of the problem is the management of patients already infected. I think it is hard for many of us to realize the revolutionary changes that have occurred in the treatment of venereal diseases in the past few years. As you all know, a fairly high proportion of 50, 60, 70%, the figures vary - respond to sulfathiazole in cases of gonorrhea. The rest of them respond to penicillin if there is any penicillin to be had. All our efforts should be designed to discover the patient as quickly as possible and to bring him under medical care. Anything that keeps hims from medical care is against the best interest of the soldier, and the unit to which he belongs, and certainly punitive measures do not help out much. They outlive their usefulness. I gather that there are opposing influences with regard to shipping people overseas. On the one hand there is the pressure to ship individuals with venereal disease because of military necessity, manpower, and what not. Secondly, the unit commanders want them to be shipped. They don't like them to be taken out of their units. Thirdly, is the question of purposeful infection with a view to be taken out of a unit. Personally, I think we are inclined to over-emphasize that but nevertheless it is one of the factors and then I assume that Port Surgeons do not wish casuals hanging around more than necessary. On the other hand, there is certain pressure to withhold cases from transports. That comes principally from the theater commanders. At the moment considerable pressure from the ETO not to send infected men over or at least not to have them arrive there in an infectious stage, and as I indicated some foreign governments have done the same. Secondly, I assume transport surgeons are very busy and they don't want to be loaded down with any more sick people than are necessary. Now then, what are the problems? In the various steps and first in the staging areas?

The first problem is one of early detection. What mechanism are we going to set up to discover these people as quickly as possible after they arrive at the staging areas? As I understand it, there is a physical inspection which is supposed to be made within the first forty-eight hours. I gather that everyone is extremely busy during this period and there is some question as to whether it is practicable to do a good physical inspection. I think we have to do more advertising to the soldier selling him the idea that if he is infected to report to the medical officer, and as I indicated before, you have to divorce from punitive measures. You can't say to a man, "Please report if you have any infection" and then turn around and punish him. I would be interested in hearing some comments on how we can pick up these cases early so that he can be cured before the time comes to go on transport. Now secondly, with regard to the method of treatment, should the men be treated on duty status or should they be hospitalized immediately? I am speaking now of gonorrhea because the syphillis and shankroid cases have to be hospitalized until they are non-infectious. That was another question that I would like to hear some comments on. If patients can be hospitalized without interrupting their regular duties, perhaps it is better to do so. Perhaps the results are a little better in the hospital because we can give higher doses. On the other hand, treatment on a duty status is entirely practicable. The results appear to be almost as good. Their complications are no higher in frequency. Thirdly, it is the question of penicillin. Should penicillin be used in the staging areas and I think certainly the answer is yes to that if the penicillin is available but that puts a real responsibility on the staging area because there is very little penicillin and it must be used only in those cases that are truly sulfanamide-resistant.

Secondly, what should be the policy with reference to shipping venereals. I think that we are all agreed that early syphilis, primarily secondary, should be hospitalized until they are non-infectious which should be 6 to 10 weeks. All newly discovered cases that appear to be respondent should be shipped if pencillin is available. We believe that all cases, regardless of their stage, unless they have complications, could probably be shipped provided the medical services are sufficiently adequate to take care of them on board ship. Lastly is the question of specialized personnel. If there is one thing we have learned in the last two years it is that many of these administrative problems can be much better handled by specially trained individuals. We realize that there is a tremendous shortage of doctors, that all of you don't have adequate allocations. On the other hand, if there is a large problem as there is at some of the larger ports, we believe that it will save manpower in the end by having a veneral disease specialist who has nothing else to do except to carry through this program.

LT COLONEL FARR:

The meeting is open for discussion.

BRIG GENERAL DE WITT:

In your opinion, would it be a proper policy for the Commanding Officers of home stations to ship all gonorrheas uncomplicated to staging areas and there should they be held before being shipped overseas?

LT COLONEL TURNER:

It is exactly the same problem in the home station that you meet in the staging area. The unit commanders do not want to take these men out. I believe that we could handle them better by concentrating our efforts at the staging areas. I thing it is largely a question of not detecting these people that are sent.

LT COLONEL FARR:

Any further discussion?

COLONEL HELTON:

I don't want to be hogging all the time but when I was out in Colonel White's area I heard one thing that I think could be adopted very beneficially in all of our areas. For instance, the mechanical sale of contraceptives, that is the rubbers and the chemical contraceptives. He has out there in one of these areas where you can insert in one side 15¢ and a dime in the other and the men can get it without having to purchase it from some female clerk in the PX or some man that is selling beer in the beer-garden. He has got stuff back in a drawer there, and he has to open it up and get it out. Some of these fellows will hesitate to get that if they are not furnished them. Now, these mechanical dispensers are made somewhere on the West Coast, and I think they are a good idea. It is a slot machine. I am going to try to adopt it if I can get it. That is so much for the purchase. Now our method of handling our venereals here. We have just got out a new directive and Major Schwartz, my venereal disease control officer and I, would like to have him state something on just what we want to do and get some suggestions from the rest of you.

MAJOR SCHWARTZ:

Our plans are fairly complete, though we believe we have some hookers to work out of the plan but in respect to movement and treatment of venereal cases at staging areas and then their handling from the staging areas to the transports. In the first place, we are trying to put in measures which will pick up these cases at the staging areas. We then plan to alter our present plan which is now a test of a plan at task force units at the staging areas. We believe we can handle them better if we are given them at the hospital and give them intensive test treatment. This Circular No. 129, permits us to give 4 grams in one dose and after that every 24 hours. At the present time with treatment on a duty status, the men are treated at the staging area and from there put on the ship and it may mean a day or two, sometimes longer, before those men are looked at by the Transport Surgeon. Usually the staging area gives the man himself his medication depending on him to take it. Now we know that many of these men will have a temporary response to one or two days medication and may not report to the Transport Surgeon for continuation of treatment until three or four days out and by that time they have relapsed and then the results of treatment are not so good. So we do feel that the continuity of treatment is the important thing in getting away from too many sulfanamide-resistant cases. What we plan to do is to hospitalize all of these men at the staging areas, then when the time for shipment comes to group them in who are going to each individual ship regardless of the unit to which they belong, and send them as units under supervision to the ship on which they are embarking. Our report will come into the Port Surgeon and Transport Surgeon listing the venereals that are coming on each ship. The Transport Surgeon then will either place them in the ship's hospital immediately or, if the number is too large and they cannot be admitted to the ship's hospital, he will then designate a section of the ship as an additional part of the hospital area. In other words, these men do not have to be in the hospital but they do have to be some place where they can be restricted, where they can be watched, and where the medication can be given on time. In addition to that by having this report come through the Port Surgeon's office telling us how many venereals are going on each ship, particularly in regard to gonorrhea we can estimate a little better how to make the best use of a small supply of penicillin which we have for placing on transports. Our attempt then, further, is that when they get on ship that this intensive treatment will be continued. That is one gram every 24 hours for 5 days and the further treatment will be the same. That is, if they fail to respond and there is still time after the second or third day interval following failure on one course, a second similar course

will be begun. We then further plan to place on the ship a supply of penicillin to cover the cases or, to put in another way, so as to reduce in every way possible the number of cases reaching a debarkation in a symptomatic stage to be accomplished somewhat this way. Say 72 hours before reaching the port of debarkation, those patients who are still symptomatic will be given penicillin. In other words, those that need it the most will be given it first. Those that seem more likely to respond without it will be skipped if the penicillin is not available. We feel then if we can give continuity of treatment, cover it with penicillin as much as we can, that we will reduce the number of cases of gonorrhea reaching the port of embarkation in a symptomatic stage. Further, we ask the Transport Surgeon to submit at the port of debarkation a report of all men with venereal disease in a symptomatic stage so that the surgeon of the port can dispose of them, we hope, by hospitalizing them until they are all right so that they can travel with their units rather than sending cases from the ship in a symptomatic stage on with their units with the potential spread to that area. That in brief is our plan for trying to ship these venereals and we know that there will be a good many problems all along the line but unless the thing can be accomplished with this continuity, we are going to have too many venereals reaching the other side. I would like to put in a couple of things while I am here. The men at the staging area, after completing their processing during which time they do not have any passes and up to the time of the alert for movement to the ship, have only 12 hour passes which makes it an ideal spot if we can work it to put in this prophylactics for treatment, for gonorrhea at least. Now the problem, of course, simmers down to how to handle units who in the past have had high rates. According to Surgeon's General Circular, this treatment can be given only to units who have had a gonorrhea rate of 50 or more per annum. This boils down to units, colored groups, because there probably aren't more than a handful of white units in this country whose rates for 6 months period have been anything near 50, while colored troops in the great majority will have a rate in excess of that. So, what we hope to do then is put in a plan like this that all units having high rates, members of those units when returning from a pass at the staging area whether or not they have been exposed, they will be given prophylactics. We have received permission as well to allot some penicillin to the staging areas. We intend, of course, to use it only for task force personnel and the problem there has been something like this. A man in task force does not respond to sulfanamide. He must be sent to a general hospital which takes 2 or 3 weeks before he gets back to the staging area. By that time the necessity of withdrawing him from his unit etc - we feel then that if that man can be given his penicillin at the staging area, there is no reason why he cannot stay with his unit. We plan to allot that carefully though, on individual requests of that kind.

LT COLONEL WHITE:

I would like to say one thing on the machine dispensing prophylactics. We found our rates dropped considerably after using these machines. However, an ordinary cigarette vending machine can be converted into this use. We just about had the rate down when we began to get colored troops and our rate jumped up.

COLONEL LOWRY:

The problem is difficult at Hampton Roads because we are drawing from casual units largely and that is to reach back to the home depots and get them to initiate a complete venereal register. Syphilic rates have come down very well. Frequently, we do not get the information on these people until they make their 48 hour visits. If we can get these lists of all venereals of all types, we can initiate the treatment on the same day. I believe this will add a great deal to this continuity and we are in the process of working on that at the present time and I think it is going to be a help to us.

LT COLONEL FARR:

Any further comments?

MAJOR FULTON:

Speaking from the experience of a battalion commander of colored troops I might answer two questions that were brought up. This particular battalion had an almost astronomical rate and it was made up partially of troops who had avoided overseas shipment by becoming infected and being kept in the hospital and at the approach of a shipment again, became reinfected hoping to go back to the hospital. Apparently, they are going to do that over and over. They instituted duty treatment of this intensity type and to insure that they actually got the treatment, the first does was given at the dispensary and at such times as the men were near the dispensary. If the troops moved out into the field, the tablets were given to the platoon leader or a reliable section sergeant who, at the correct time, saw the man swallow a pill and there was no question about getting it. The rate fell into the limits of white troops very quickly. As for the contraceptive side, it is rather helpful giving them to colored troops. Suppose they leave early in the evening and stay away all night, they simply don't use them. We broke that up by requiring everyone who came in for a pass to take a prophylactic. That and the discomfort and the having to get up every 4 hours to take a pill brought the rate down very abruptly.

COLONEL BRADISH:

You think you people have trouble. I am from New Orleans. We have approximately 50% colored strength and we have all the blue ribbons that could be awarded for the last two years for high rates and the problem is everlasting. I hate to even start going into the details as they exist. Colonel Turner has been very helpful to us and we are batting away at the problem. As you all know, the 4th 5th and 8th Service Commands have, and always have had, the highest prevailing venereal rates and the 1st, 2nd and 3rd Commands have had the lowest venereal rates. We think nothing of a rate of 600 per thousand of a unit down there and that rate has prevailed. Application of effort over a period of many months has resulted in an overall reduction of that rate down to around 250 per thousand. That is colored rate. The white rate is below 30 per thousand. Our problem is not alone for shipments overseas, but due as well to the fact that there are a large number of units activated and trained in and around the New Orleans Port of Embarkation. We have tried every way known to influence the rate. We experimented with several battalions - colored battalions. We gave them a gram of sulfathiozole when they went out on pass and gave them another gram when they returned. We reduced the rate to zero in those units during those periods. Now it is practical to go ahead and put out mass sulfathiozole therapy and control this in a staging area. We ran many thousands of urin analysis and blood checks. We don't think we have hurt any of these people. We limited their passes to twice weekly. As it so happens, however, approximately 50 to 75% of the cases occurring made their contact in and around the city of New Orleans. We can't reach the man who is on furlough at home. This seems to account for about 50% of our cases. The only way he can be reached is by education and by furnishing him the technical materials necessary and having his cooperation in the use of them. The matter of prophylactics, sulfathiozole to the unknown exposed cases on return from pass work well with white troops but not with colored..You can't get anything out of them as to whether they had an exposure or not. We have had fair success with the ambulatory treatments of colored persons but we have had to resort to a procedure the Major has outlined. You can't give that colored man 40 tablets with a routine and have him report daily to the dispensary for his progress study. He simply won't take it. You have to watch him take it personally. Therefore, you have to delegate that back into the unit. If you have a good cooperative unit commander and first sergeant, charge

of quarters, etc., who will see this thing through you can get excellent results. There is one thing that I would like to point out at this time and that is that I think it was in the month of May a directive came out with reference to furnishing at ports of embarkation a trained, well-qualified venereal disease control officer. That came out just prior to the turnover in the management of personnel allotments. We were to requisition officers if we had available vacancies at that time. We didn't have any. At least, I didn't have one and I certainly haven't had any available vacancies since that time for the requisitioning of that officer. I am wondering if steps can't be taken to provide the Chief of Transportation with the necessary allotment increase to actually furnish us with the skilled, well-trained venereal officer.

LT COLONEL FARR:

Colonel Heiskell, can you answer that last question?

COLONEL HEISKELL:

Colonel Turner and I discussed that subject at the time the directive was published in May. There has been a considerable development in personnel technique since that time. We felt that New York and San Francisco and possibly New Orleans were looking at it from the standpoint of overseas shipments which would justify an officer who could devote his full time to this important matter. We felt that in the other ports due to the scarcity of personnel that a part-time officer who specializes in that subject could handle it. That was just our general feeling which was a quick decision. After all, one officer so far as the allotment is concerned, I think can be worked out. I am not from the Personnel Division. We have an officer here, but he is from the civilian outfit. The Surgeon General will concur that it is needed as a full-time proposition. If not, you will have to fall back on part-time. I would be very glad to take that up with our personnel (military) when we return to Washington.

BRIG GENERAL DE WITT:

I took this up with the Port Commander or Chief of Staff. I said we needed this man very much and the thing went back, as I remember it, to my office with an indorsement. We needed this man but we had to have an increase in the overall allotment for that officer in that grade.

LT COLONEL FARR:

In other words, there are too many in the port but they are not in the Port Surgeon's Office.

BRIGADIER GENERAL DE WITT:

I say there are not enough in the port anywhere.

LT COLONEL FARR:

We have had a very fine discussion. Thank you very much, Colonel Turner.

In these times when the sources of water supply are very well controlled the problem of coordination and control of potability was very simple. We have now reached the stage where transports may pick up water at nearly any place they touch. The results are that very frequently water is in bad shape and requires a great deal of work on it. We have two speakers to cover this. Captain Bonnell who has done a great deal of work in his specific area and later Colonel Harlenbergh of the Surgeon General's Office will give a further discussion.

CAPTAIN BONNELL:

Perhaps no one noticed at our charming dinner aboard this British transport last night what the water tasted like - but I drank the water. I will admit we did have liquid refreshments beforehand. I have been in the habit in the past year ofnot drinking water aboard transports. About a year ago out in San Francisco we were presented with a rather bad problem. We had to do something about drinking water on the transports and at the same time in order to justify our results, or lack of results, we had to conduct a certain amount of research. Now the disease organisms which we were attempting to combat are taken into the human system through infection primarily, through food, and through water, but you can't draw a line down the middle and put food on one side and water on the other and always say that the disease which is being produced aboard transports or with the troops when they get to the other side are occasioned by either being picked up by food or water. As long as we don't have the necessary data there is no proof of that. Where food is concerned, we can run laboratory tests occasionally aboard the vessel. You have your food examination, Sanitation Corps, inspecting the food analysis. Sanitation conditions in the galleys - as far as water is concerned has never up to this time made any specific progress. Perhaps you can account for France being a nation of wine drinkers and England being a nation of tea drinkers by saying that England hasn't the water that Franch has. Yet at the same time we are attempting the greatest mass transport of troops in all history and we are definitely not giving them the necessary precautions as far as water conditioning is

concerned. When Sir Francis Drake took his ships off - even as late as our great clipper ships - even as late as 1940 - we were not conditioning water. Sir Francis Drake carried his drinking water in hogs heads usually coated with pitch. Later on, we began to install steel tanks in steel vessels. We lined them with cement because of the reaction of water against iron and steel, causing rust and sediment. But still we were just dumping water in the tanks and assuming that because the source of the water, that is the city water which we loaded, was pure or relatively pure, that that water was going to remain in a pure state. Such, of course, is absolutely contrary to the facts. In the Pacific, we have been faced with a problem of ships travelling slow circuitous convoy routes picking up water at stations which did not have approved sources of water. Using ships to carry a greatly increased operating personnel and having a tremendous increase in the number of passengers, that is military personnel, and yet for their drinking water you only had tanks which were in those vessels for normal personnel and normal operating personnel and normal passenger lists during peace time. That meant that certain tanks had to be constructed aboard the vessel, or, as is more often the case, there had to be a certain number of tank conversions. Tanks which might formerly have carried gasoline, fuel, oil, or in the case of some of the Dutch ships, cocoa, oil, things of that shape had to be constructed. I am very fortunate, I might say blessed and also cursed, by having an old time Army Sergeant on my post. After he gets through my hard head exactly what I should do then I am all right. One Sunday while at work he was trudging through the rain. He works on Sundays because his wife wants him to go to church. He was passing by a street where a water main had broken and he saw a strange contraption out there. A trailer, two wheels had flasks of some kind or cylinders and they had pipes sticking down into the main and there were a couple of men fooling around so his natural curiosity got the best of him and he found out they were using a sterilizer. They were applying chlorine gas to a broken water main or one which had been broken and they were attempting to cleanse the broken main, the pollution that had been picked up at the time it had been broken. As I mentioned before he had to do something about our water supply aboard transports and at the same time justify our results or lack of results by research and by statistics. In that connection, during the past 11 months we have taken more than 4,000 water samples from aboard ships carrying United States military personnel. Taking a water sample is not as simple as it sounds because first you have to have sterile bottles. Second you can't merely go aboard a ship, turn a tap, and take a sample And when that sample is analyzed consider that you have an adequate representation of the potability of the entire mass of the ship's water aboard. You have to take samples from a number

of tanks and a number of taps from the various parts of the ship. We attempt to take ten. We still don't feel we have a true picture but in view of our limited personnel, time, and other things of that sort, we consider that number sufficient. Until recently, we have been taking samples on Navy ships and War Shipping Administration ships. We handle on the water sample up to 10 or 12 ships a day. We take water samples upon their arrival. We take them while they are in port and we take them just prior to their departure. To get back to the machine the sergeant saw, as I say, he told me about it and I went down to investigate. We made certain connections so that he could begin using these (pointing to diagram). Assume this is a cross section. A line is dropped into that tank. A certain amount of chlorine gas is injected into the filling line which might range all the way from 100 parts per million to extreme cases of 300 parts per million. In other words, you have a heavy saturated water-chlorine solution pouring into that tank. As that tank slowly fills up, organic matter which might be deposited on the side or on the bottom is affected by action of the chlorine. When that tank gets filled 4, 6 or 8 hours later, the other tanks are filled; that chlorine water is pumped through the circulating system of the ship. There are sometimes millions of pipes in that connection. The machines are then disconnected and the whole mass of that water is dumped overboard and the tanks are as we consider them sterilized. In other words, we receive potable water at the port so that if you put pasteurized milk in a dirty milk bottle you are not doing any good. We are attempting to sterilize our containers. We took 20 test ships and kep figures on the potability of the water samples, before and after this sterilizing which more specifically is known as super-chlorinating. Prior to super-chlorinating the first time our potability was about 35%. That is an astonishing figure. We got that to jump up to 88% potability water samples by super-chlorinating once. It wouldn't stay there. It dropped back down to about 72%. We super-chlorinated again. It got up to 94% potability. The vessel went out on a long trip and came back. We had 20 vessels here. The vessels came back. The results were a little better - 75%. We super-chlorinated and got them up to 96% potability. In other words, we have been able by super-chlorinating to climb from 35% potability on ships water on the Pacific runs to 96% but along in here beginning about 6 months ago other factors began to enter in and I want to describe those to you briefly. First, I would like to point out and some of you know this much better than I who are more familiar with ships, that a ship will have several drinking water tanks. You have a tank in the immediate nose of the vessel which is called the forepeak. You have the counter part in the stern - the aftpeak. Somewhere in the base in one or more sections you will have water tanks known as the domestic tanks. And finally, although certainly

their use is not approved, there are certain double bottom tanks lying immediately above the keel and the deadwood. You have a great number of sources of contamination of ships water. For instance, on a vessel which we will merely call "X" - a very dirty vessel by the way, in fact, coffee comes in a better can than "X" - the engine plates and the bed bolts were very loose over the tanks which were used for water. You had fuel oil seeping in there. These tanks have pipes running to the surface called vents. There is a certain amount of contamination through there. You have constructed on a good number of vessels a little wood chenise we call doghouses. We even have deck latrines so that you have contamination for the deck into the tanks. You have plugs rusted up and also through some of these water tanks some of the sanitary lines pass. The sewage passes through there and due to the corrosive action of water on steel and iron, you always have leaks. You have double connections, therefore, in spite of super-chlorinating, we find we are not getting at the root of the problem. We still had sources of contamination aboard the ship and we had to do something about it. We began to buy and install small machines. The essential parts of the machines were about the size of a typewriter and are called a hypochlorinator. There is a mechanism which will inject a certain amount of chlorine solution into the water manifold aboard ships. They do not condition the ships water in tanks but they do condition that water passing through the boiler manifold prior to its consumption by troops either indirectly by galleys or through fountains. These are mechanical hypochlorinators. We set them at first at about two tenths part per million. That is that there would be two tenths per million chlorine left in that water after a certain retention of time. Actually, we put much more in there than that but it was being oxidized. The machines varying in different ships were so set that we still had two or three or four parts per million of chlorine left over. We still weren't getting at one important organism however. That is the cost of amoeba dysentery. They, ordinarily, are not susceptible to chlorine in that concentration. Yet, if more chlorine is injected into the water, you have such a high residue that it just isn't palatable any more. You can't even drink the stuff. To get up to 10 or 12 parts per million with a sufficient period to ill the cyst of amebic dysentery you will have to find some way to make the water palatable. Because of that we used an activated carbon filter and began passing the drinking water through that after the water had been highly chlorinated. We figured the cyst had been killed by the 10 or 12 parts of chlorine. The water was dechlorinated by passing it through the filter and it came out the other end free of chlorine, was clear, soft, and about as good drinking water as you can find. There is still one small objection to our system and that is there is no chlorine residue in the water after it passes the filter and still has to pass through con-

siderable piping before it is finally consumed. That can be overcome by one of two ways, possibly more, either by putting a little sifter valve on the side of the machine, or you might back-track your water through the chlorinator again, a dual chlorinator or through another one. On our tables there are a certain number of sketches, some showing the set-up. There is a sketch or picture and then there are a certain number of others which an engineer would have very little difficulty in following. I think practically all of the tables have this large sheet showing the picture. This is a picture and not an engineer's drawing. You will note in the upper left hand corner that there are water tanks. The water passes out from those tanks to the mechanical hyserchlorinator where a certain amount of chlorine is injected into it. Finally, it goes to a retention tank where the chlorine has sufficient time to oxide bacteria or protozoa before passing through the filter or the chlorinator. A good number of vessels already have a gravity tank or pressure tank installed which can be used for that purpose. I don't care to go into any more technical engineering details because I am sure you are not interested in those things right now. We have tried to raise the potability of ship water to about the neighborhood of 95% - that is our result. I would like you to keep these drawings and make any use of them that you can. I would like to turn the balance of the discussion to Colonel Hardenbergh, Chief of the Sanitary Engineer Branch, who will have something to say to you on the subject.

COLONEL HARDENBERGH:

Captain Bonnell has gone over this situation and showed you graphically and with the aid of that excellent drawing very nicely how these things can work. Now it really doesn't take very much data to be sure that some work needs to be done along this line. Our own experience in sanitary and public health engineering in civilian life and over many years has shown us by actual experience what may happen under the conditions that we have in supplying water to the ships. There are a number of records in the Surgeon General's Office which pretty clearly and perhaps not completely incriminate water supply. We have records of one or more outbreaks on docks where the water has been contaminated in a way that I will explain a little later. I believe that in the records of the San Francisco Port of Embarkation there is very strong evidence of the incrimination of water in intestinal outbreaks on ships. However, as I said, it isn't necessary to go into those records. Our own experience in civil life, in hotels and other structures are somewhat comparable and have given us opportunities for the decontamination of water. The conditions are

much more favorable for accidents to happen on ships than they are in hotels and other places. Now when we go to carrying out any program of this type we run across a great many complications. First, we want to regard the structural features of the ships and the conditions in which they are operated these days. First, we have two or three or four or sometimes more water supply piping systems within the ship and we have drinking water, bathing water, salt water, and I don't know what else. We had those things come up in our hotels in Atlantic City and some of us almost got gray hair. When the troops went in there, and packed into rooms as they were, they were using three systems of water supply - private wells, city, and salt. In ships they have esentially the same condition. Now as Captain Bonnell pointed out, when your troop ships were converted to carriers, they had much more water carrying space and as he showed here, double bottom bilging tanks, converted liquid cargo tanks, etc., all used for water supply. Now aside from the difficulty of keeping those tanks clean and sterile there are many opportunities for contamination through manholes, through sounding line holes and vents and opportunities of that sort so that unless we have quite a degree of perfection through reconstruction, rebuilding of these things, we are going to have trouble. It didn't make much difference if a little oil leaked down here or a little contamination leaked down into these tanks when they carried oil or something of that sort. It does make a difference when they are carrying drinking water. Then we want to remember that these ships are a maze of types inside. It is almost impossible to follow up any individual pipe line and the opportunity for a hurried plumber in making an error and connecting to the wrong line is so great that I don't doubt that it is done more frequently than it has been done. We expect it to occur and it will occur. Then, beyond that, in our ships we have many additional chances for contamination. In some cases sewers pass through some of these tanks that have been converted for carrying water. We must remember that a good many of our ships have been in use for 10, 20 or more years and during that time they have had what you might call a local plumber working on them, their own ship's plumber and sometimes a great pressure to reduce repair costs has been effected--a thing that happened in the hotels during the past years. Many of our hotels have been on the verge of bankruptcy or up to their necks in it and in repairing and in maintaining their plumbing systems, they have gone to extremes that are really fascinating from a crying viewpoint. Then we have also many additional chances for contamination - cross sections, possibility of leakage into the tanks - the use of water of tanks as ballast on return trips, so perhaps you might be inclined to agree with Captain Bonnell when he said he didn't drink water on ships any more. Our ships are very complicated structures. Sometimes at the last minute a ship's engineer will come on board who has never been that ship before or it may

be during that re-finishing process of a ship that came off the ways over a year ago. Such a ship has lost a good deal of resemblance to its sister ships as far as piping is concerned. Therefore, we can say the new engineer is pretty much ignorant of what is going on inside that ship. As a matter of fact, Captain Bonnell informed me in the case of one ship the engineer was so unfamiliar with the lines that he dumped all the drinking water in themiddle of the Pacific and they had to get along with what the distilleries could produce on board. Our ships are carrying personnel to ports where the water supplies are not without a great deal of question, so we must consider that the ships are likely to pick up contaminated water and bring that water back on their voyage, contaminating the passenger lines and pipes used for water supply. It would seem that we can meet one condition by preparing carefully and arranging carefully rather simple instructions for the ship's personnel, both the Transport Surgeon and the ship's personnel who has charge of water supply. That probably should tell about the common types of hazards and what they could personally do. Of course, in addition to that, an adequate treatment method has been devised as in most Army installations. We have certain essential factors such as reliability - it must work. Simplicity - even some of our lower IQ employees must be able to run it satisfactorily. It must be positive in action. You turn the wheel and something happens and it should be fairly reasonable in cost. The process of adding hypo into tanks is not very satisfactory. Many of these tanks shown here are baffling. It seems to us that chlorine must be used for our purification agent. Due to this multiplicity of pipe lines and the possibility of inter-connections and contamination from outside, it seems necessary that a chlorine residual be made throughout the ship. That chlorine residual would afford a certain zone of protection against after decontamination. You can put in enough chlorine to provide you with some degree of protection against what we might call normal or chance minor contamination. Now the use of hyperchlorides seems preferable to liquid chlorine, for several reasons. I don't think we want to mess with our liquid chlorine machines around the ship. Hyperchlorite has many advantages over that liquid chlorine. It seems necessary also as Captain Bonnell pointed out to add a pretty heavy dose of chlorine, that is, to rely on superchlorination. If that is done, we then must be dechlorinated. That is, we must take enough chlorine out of the water so that the water is drinkable. That can be done in one of two ways - by adding dechlorinating agent or by passing the water through a carbon filter. We must control our dechlorination process so as to leave an appreciable residual in the water. That probably can best be accomplished by use of a carbon filter such as shown on Captain Bonnell's drawing and by providing by paths so that we can mix in a certain proportion the chlorinated water and thereby maintain a residual throughout

the ship. A very skilled routine inspection seems necessary at the different ports to detect and eliminate the hazards due to structural features such as those I have mentioned; or in the case of ships which have already been inspected, to see that there has been no dangerous changes in piping by the ship's plumber. Also, to provide our sterilizing service for the mains and tanks as reported by Captain Bonnell and as shown in one of his other drawings where he added 100 or more parts per million and finally managed to sterilize the pipelines or tanks in the ship. I think that is a very important routine procedure to carry on whenever our water samples or our examinations indicate the need of it In addition to our ship's inspection, we have another problem connected with water supplies at ports of embarkation and that is the safeguarding of the pier water supply. As you know the ships are now connected to the pier lines for fire protection as soon as they are connected at the docks. Quite often the fire pumps are started and as a result in a number of cities where ports of embarkation are located, we have had complaints that the water is tasting mighty salty. What's happening? We also had at New Orleans on one of the municipal piers a ship parked, tied up to the dock, and started to use the pumps drawing up the water from the waterfront and we had some 300 or more cases of intestinal diseases at the docks down there so we must make an attempt to see that contaminated harbor water is not pumped back into the shore lines. This whole program may be criticized as fighting ghosts. It does seem that we are fully justified and required in my opinion to initiate a program of control which it seems to me should include:

a. The development of adequate and satisfactory means of purifying ships water using basic equipment now available on the market. The San Francisco Port of Embarkation has gone a long way in accomplishing that although I think if we got a committee of engineers on it, we might add a few little improvements to that program that you have laid out there.

b. A provision for the installation of such equipment on ships. Now this means working the Transportation Corps, the War Shipping Administration, the Navy, the Maritime Commission and the Public Health Commission.

c. The institution of adequate inspection service at all ports of embarkation by qualified engineer personnel and I might offer you the services of some of our sanitary engineers who are members of State Boards of Health in pre-war days and who have had a great deal of experience in this general matter of water protection under the most difficult conditions.

Another step which we might label "d" would be the necessary instruction of ship personnel and transport protection and

facilities for the protection for pure water supply.

I believe if we can lay out a program of that type we can accomplish a great deal in safeguarding our water supply. You folks know probably better than I how serious a matter this is. I am not thoroughly acquainted with the problems involved in ports of embarkation. I am familiar with similar problems that have arisen and have existed for many years in State and Municipal Health Services and I don't think they are any different. Thank you gentlemen.

LT COLONEL FARR:

A few minutes now for discussion. Does anyone have questions?

LT COLONEL STECHER:

I would like to ask you if you know anything about the condition that broke out at the Hotel Congress during the World's Fair. This hotel has had Army personnel quartered there.

COLONEL HARDENBERG:

From conversations I had heard, I almost got heart failure when the Air Corps moved in. The Air Corps cooperated remarkably well and limited the number of troops going into that hotel to a number somewhat smaller than the number of guests who lived there when the epidemic occurred during the World's Fair. Since that epidemic, we had checked over all the pipes in that hotel and approximately 80% of the piping in that hotel had been replaced since that trouble started during the World's Fair. Nevertheless, we went over it and nothing was taken for granted. Of the large number of hotel taken over by the Army, we have found some very good hotels and some very bad ones, and we consider ourselves mighty lucky that we got out without a single epidemic - it really was luck. It was also the fact that the Office of The Surgeon General realized the importance of the situation and we went to work on it right away. It seems that these hotels parallel ship conditions considerably.

LT COLONEL FARR:

Are there any further questions? If not, thank you very much, Colonel Hardenberg. We will change our schedule slightly as we have had quite a long session this afternoon. We will take a fifteen minute break and reconvene at a quarter to four.

(RECESS)

LT COLONEL FARR:

The United States Government is one of the largest employers of civilian personnel at the present time, and there are two aspects in the taking care of this large group of civilians. One is from the humanitarian standpoint and the other from the purely plain business viewpoint of having fewer liabilities now and later. Major W. L. Cook of the Surgeon General's office will discuss the Army Industrial Medical Program as relates to Ports of Embarkation.

MAJOR COOK:

I would like in the first place to apologize for the absence of Colonel Lanza, Chief of our Branch, who was unable to be here today, and from whom I think you would get a much better talk and opinion of what we think a Medical Industrial Program should be.

War Department Circular No. 59 of 24 February 1943, relates to the Industrial Medical Program of the United States Army for the treatment of military and civilian personnel at Army owned and operated industrial plants, arsenals and depots. "The Army owns and operates a large number of arsenals, depots and other industrial plants the employees of which number several hundred thousand. As an employer, the Army is obligated to furnish safe and hygienic working conditions and to maintain an adequate industrial medical service. The extent to which women are being employed in Army plants make this doubly important. The purpose of this circular is to clarify the functions and scope of the industrial medical program of the United States Army" That was not our statement. That is the statement of the Adjutant General, who charged the Surgeon General with that responsibility. It has been enlarged to include industrial plants arsenals, and or depots and we're very glad to see that the Chief of Transportation decided that Ports of Embarkation can be considered as industrial plants. I understand that he has recently issued a directive that the ports will follow, WD, Cir, No. 59.

I would like to tell you about the Industrial Medical Program, what it has accomplished and perhaps questions from the floor will settle the problem you people might have built up in your mind since receiving that recent directive from the Chief of Transportation.

I am glad that Colonel Farr introduced the subject as he did. I would not have liked to have him ask me to talk about the occupational hazards of dockworkers and stevedores, because I don't know much about that; I have had very little opportunity to go down to the docks. I do think that we have people in our

outfit who are acquainted with that problem. It is very difficult in one respect to detail what the Surgeon General's Office has done with respect to the Industrial Medical Program in the line of directives for the field, but I think I can explain that to you a little bit. In our latest count, there are some 610 Army owned and operated industrial plants, arsenals and/or depots in the Continental United States; that includes anything from a sub-depot in the Air Corps to a large arsenal, munitions depot or chemical warfare installation, and in that particular group, there are some 850,000 to 900,000 civilian employees, 30% to 35% of whom are women. These figures definitely make the War Department the largest employer of civilian labor in any industry in America today. We haven't written many directives for the field to tell them how to do this and that, as an explanation of the lack of written directives; let us take the example of three chemical warfare plants all manufacturing the same thing. One is a military pilot plant. This is a small plant, but it has had a few people working there since the last war and they are putting out a little bit of their particular item. They're working in an old 1918 plant which has been remodeled to a certain extent. We will go to another plant making the same thing where each particular part is made in various parts of the plant, each part about three miles from the other. They all have their little nucleus and know how to work this plant; everyone of the three buildings in the three parts of the second plant are all manufacturing the same brand new thing.

Then we have another plant where they have a similar organization that is really on a production scale turning out mass quantities of the same item. The hazards that occur in manufacturing this item very frequently in each plant. If there is a spill of a toxic product in the old plant, it gets on to the wooden floor and seeps in creating constant hazards. Some of the newer plants have floor covering where the stuff can be cleaned up within a period of several hours and the hazard is eliminated 100%. In a place where they are manufacturing chlorine in one particular plant and piping it to all the other places, with each individual plant manufacturing items of chlorine, I think you have an example of the problem facing chemical warfare service and arsenals in issuing directives on health procedures and industrial hygiene procedures that will cover all three plants. Therefore, the Surgeon General's Office, when it started this rather prodigious task less than two years ago with perhaps 450,000 employees which figure is now at least doubled, thought that the best thing to do was to put qualified men into a position where they could write their own personal directives on the spot. We have had very satisfactory results in that respect. Not long ago, we had two industrial hygiene manuals sent in to us from two Army branches both 100 to 150 pages long, covering the hazards and prevention and care of people affected with occupational hazards as they were found in just those particular Army branches - so that we could sit

down in Washington and write an industrial hygiene manual and sent it out to you people.

I think that the Port of Embarkation probably very well could have a separate industrial hygiene manual made up by people at the Port knowing what the problems are. We could not look back into literature and find out much about these particular situations today.

One of the bibles of industrial hygiene stated that very little has been written on dock workers. Yes, undoubtedly, there is much to be desired in the industry regarding the hygienic aspects of their work. It went on for a few pages talking about upper respiratory and infectious diseases. That is a big problem in Ports of Embarkation because men are working under all kinds of weather conditions, frequently going in and out of ships and up and down the docks. What, then, can we do for these employees that are working at the Ports of Embarkation? We appreciate the problem only too well, being only three floors above them in the Military Personnel Surgeon General's Office. In fact WD Circular No. 59 states: "Increase in allotment of medical officers to service commands will not be made for medical service in Army industrial plants, except under unusual circumstances and for specific assignments. Requests for medical officers designated as required for unusual circumstances and for specific assignments will be approved by the Surgeon General's Office before being forwarded to the Military Personnel Division, Headquarters, Army Service Forces. Medical Department personnel may be secured for the Industrial Medical Program as outlined in Section II, Circular No. 2, WD, 1943". That makes it hard to outline an ideal situation at the Ports of Embarkation, but I think I ought to tell you what we would like to have done and I can tell you that Colonel Lanza will do everything that he can to help out.

There is a reason from a humanitarian standpoint for having an industrial medical program. If the civilian employees in your Ports of Embarkation or any of the big air fields walk out on you, you won't get your ships out. If you make those people feel that they are part of the war and they're getting just as good service as the fellows that we're trying to ship out; that they're not being passed over and are just as much in uniform as anyone else, I think perhaps this morale point of view will pull up production a little bit more. That this is a fact has been proved in industry, and I am sure that it can be proven in any agency in the Army at the present time.

The industrial medical doctor or medical officer has to have a different point of view than that of the regular doctor. In the first place, he is putting a well man into work and he wants to keep him well. He doesn't want sick people on the

job. He wants to prevent him from getting sick. It is the old Chinese method. It is just as different as pediatrics is from adult medicine. The industrial medical man, therefore, should be a full-time man, and he has to know what the employee does and what happens to him when he does it and if he doesn't know that, he isn't much good. The industrial medical man, therefore, should not spend his time in the dispensary. He should get out and see what is going on; see what these people are going through and improve conditions without holding up production and without causing trouble in his plant. We hope that the general industrial medical picture in the Army will result in the correction of mistakes when we see the causes of absenteeism. After all, that is what the Industrial Medical Program is for, to cut down absenteeism. Long experience has shown in private industry that labor did things because they had to. Labor got mad and went to the extent of having laws passed - statutes - and then you had to have a doctor around to take care of the fellow who got sick or injured on the job. At the present time, the roster of industrial medical men in the country shows fewer surgeons than medical men. In other words, they are properly placed in the Surgeon General's Office because we believe industrial medicine is preventive medicine. I think from that standpoint that you can see why the industrial medical men should be a full time man, that he shouldn't have to be bothered or have part of or most of his time taken up with other duties. You can't expect when you get one officer, as an industrial medical officer, to get additional medical officers to help run your show; the man you do get must be an organizer. To give you an example of that, we recently went over the figures as to how many doctors were working in Army industry by percentage of people employed. Forty percent of our plants which figure covers sixty percent of the population - these are the larger ones where we have a better setup at the present time - we have roughly one doctor to every three thousand employees, and we have one nurse for every seven hundred and fifty employees. Contractor-operated, government-owned plants have one doctor for every 2,000 employees and one nurse for every 500 employees. One of the best medical services in private industry in the country, proved to a company of 45,000 employees that in one year they saved from infection and lost time over a million man hours. That particular company has one doctor for ever 8,000 civilian employees and one nurse for every 800 civilian employees. Now we don't do that well in the Army, because we don't have 45,000 people concentrated in one place often enough. If you will divide 640 into 850,000 you will see why.

What should the industrial medical service consist of? It should consist, in the first place, of properly placing the man in his job in order to complete that job. We have to have co-operation. We know there is a man who hires the individual,

and there is a man who finds out if he is fit to go to work, and we admit in the army, we are not able to have our own men examine the employees as often as we should like, although that situation is improving all of the time.

The usual practice has been for the civilian employee to obtain a medical certificate from his family doctor that he was in good condition for the performance of the job, for which he was applying. Because of the fact that this doctor might have been taking care of Joe for sometime without getting paid for it; when Joe comes in and applies for a job to work at the New York Port of Embarkation, the doctor will be very glad to fill out the form that was given to Joe, and won't care too much what he puts down. Not only that, you have the Civilian Personnel people saying: "We want this fellow to work in a certain place", and on the basis of the form the doctor has filled out, you should be able to decide whether or not he is physically fit to work there.

Then you have to be able to take care of this fellow when he gets to work. What do we mean by that? We don't mean you have to have a doctor for every 400 people working. You can have one medical man in charge of four or five first aid rooms in the dispensary. Many times, by having a place where the man can go when he gets hurt or feels ill, he can be discouraged from staying out longer than is necessary. We also feel that it is important to take care of anyone who gets sick on the job, whether or not it is service-connected so long as you can keep him on the job that particular day. It may be some sort of illness that requires him to go home then, certainly he should go home. I'm talking about headaches, hangovers, sinus attacks and things of a temporary nature.

When we talk about what the Surgeon General and other people can do, as far as the Medical Industrial Program is concerned, there is, I think, a sufficient number of men in the Surgeon General's Office who could be used as an advising and consulting group. I'll say this much, if we don't know the answer, we will find it out.

We also have some other help for you and that is with regard to the Army Industrial Hygiene Laboratory. Now, this is a laboratory in Baltimore, Maryland that is staffed by trained medical officers and industrial hygiene engineers commissioned in the Sanitary Corps who can tell you whether any of your employees are working under hazardous conditions. They can sample the air - the dust in the air, or anything that is chemically in the air. They can tell you whether your lighting and ventilation is correct. They can tell you how it can be improved. Any-one of the ports can

have what we call a complete industrial hygiene survey made at any time upon request. I think, the problems that will come up in the instituting of an Industrial Hygiene program or an Industrial Medical Program at the Ports of Embarkation can be better solved by answering questions.

I have tried to outline what we have done to a certain extent. As far as accomplishments go, we have some 120 medical officers and roughly 80 civilian physicians working for the Industrial Medical Program for the army at the present time. I can't give you the total number of nurses off hand. We have erected and equippped adequate industrial medical dispensaries at some 178 plants throughout the United States. You can get any surgical or medical equipment from the list of the Industrial Medical Dispensary (97256.03) and I think you will find that that will handle most of the situations that you will come across. If there is anything we can do for you in Washington, we will be only too glad to cooperate. Colonel Lanza has been at the New York Port and has submitted a survey of what he thought needed to be done in the Port. I am sure that if similar surveys are needed, they can be made at the other Ports of the United States.

LT COL FARR:

We are fortunate in having with us this afternoon, Lt Colonel Corey. Would you like to say anything in this connection?

LT COLONEL COREY:

I would like to ask one or two questions which occurred to me before the survey was made. As you know Colonel Lanza came over and talked to us about the original directive of Headquarters, Army Service Forces, shortly after the reorganization. The Civilian Personnel Sections in each installation were charged with what has been designated as a health program. The question of the relationship of responsibility for that health program, and the Industrial Hygiene Program which is now the responsibility of the Surgeon General's Office, I think, needs some clarification which would probably help in instituting such a program in the Ports of Embarkation and other installations of the Transportation Corps. In years gone by, there was a good deal of question as to how far the Army could go under the various appropriation acts in providing pre-employment examination or post-employment medical assistance or examination for civilian employees. With arrangements that have been made through the Surgeon General's Office recently in connection with the medical appropriation which provides that that fund can be spent wherever it is obligatory -- "arising by reason of regular contract", or one other term there - -

I forget what it is -- its a pretty broad term which we used recently in working with your office intaking care of medical expenses; it seems to me these arrangements eliminate much of the difficulty which has arisen in the past in connection with the expenditure of funds for civilian and seaman. I believe that the Civilian Personnel Sections in the Ports can be helped, if, under the responsibility of the Surgeon General, we make it a rule tohave the medical certificate to which you refer, completedaat the Port by the Industrial Hygiene Medical Officer, prior to employment. Of course the questions that come up are practical ones * assuming that it can be done legally - the questions that comes on that is whether or not there would be sufficient personnel for this suprise and I believe Colonel Lanza in talking to us about it indicated that, while there might be some difficulty in extending it to its maximum extent, it might be done by contract medical care. I know that it is being done in some degree; the degree varying from one installation to another. In general, a civilian employee will, at his own expense, take themedical form or certificate that has been given to him to a doctor for the required examination. I believe that the discussion that wer had about seaman, inconnection with the appropriation acts, opens the way to establishing a definite policy that the medical form shall in all cases be filled out by a medical officer at the expense of the Government perhaps through this Industrial Hygiene Program. I would like some comment on that point.

The second point that I had in mind is that I would like to ask about how far the Civilian Personnel organization can lean upon such an organization; when, as and if it is established in combatting cases of absenteeism. There is now operating in all Civilian Personnel Divisions or Civilian Units in the vasious installations what is known as the Employee Relations Program. That program has been directed to us in some detail, requiring thata certain amount of preventive non-technical health education andhealth matter be taken up or handled by such employeee relation units. Typically, a man stays out. He may of may not call saying that he is ill. The Employee Relations Unit which is set up is supposed to attempt, insofar as their personnel will permit, to go to the man's home to find out that is wrong with him; normally, if the man is not ill for more that 2 or 3 days, his statement can be accepted as to his having been ill. If it runs beyond three days, he is required to have a medical certificate. However, to close the gaps of that 3-day period in successive groups of one or two days, the Employee Relations Groups would refer all such cases to an Industrial Hygiene unit operating on the policies laid down by the Surgeon General. It would seem to me that some such line of demarkation might be the proper one if that is within the concept of the Industrial Hygiene Group. I take that as a typical case where the relationship may vome together. There are other cases. Those two questions are the ones I think your comments upon which would be appreciated.

LT COLONEL COOK:

In answering the first question Colonel, The Surgeon General's Circular of a year ago which has not been rescinded states that Medical Officers of the United States Army do pre-employment exams of Industrial War Department employees. Roughly, those are the words.

LT COLONEL COREY:

It is "may", however, rather than "will".

LT COLONEL COOK:

That is entirely a question of personnel at the post. For instance, we realize that at many places we can't make medical officers do pre-employment physical examinations. The reason that the circular was put out was that about three weeks prior to the circular, there came out from the Adjutant General a statement that medical officers would not do pre-employment Civil Service examinations; we had it changed to the extent that medical officers may do pre-employment physical examinations on industrial employees of the United States - of the War Department - and it was done that way, written from our office, in order to enable us to use medical officers for the examinations. Now, as to getting examinations done at the expense of the War Department; as I understand it, you cannot give Johnnie Jones $3.00 and tell him to go and get his physical examination, but you can hire civilian physicians or contrzct surgeons and put them to work doing pre-employment examinations or some such other work in the industrial program that you think they should do. War Department Circular No. 2, I think the date of it is January 1, 1943 states that civilian civil service physicians may be hired and used in the industrial medical program of the Army. It was our intention at that time that Grades of P-4, 5, and 6 would be used. We have found, since, that some civilian personnel classification sections, using a 22 year old classification of doctors, feel that most doctors are first aid men anyway and don't rate more than a P-3. Contract surgeons want more money than is allotted in the Circular or they would quit. We couldn't even get anyone that we could put in charge of a few dogs and cats with a contract surgeon's compensation. After all if a man isn't good enough to earn a good living today in medicine and is willing to accept a contract surgeon's job where there is no promotion and where there is not any way of advancing his salary, he probably isn't going to be of too much good to you as an industrial medical doctor. However, we do have some very patriotic individuals and retired Army Officers and other people who want to be in this war, to be in a uniform, who can't get into the Medical Corps. They are willing to take a contract surgeon's salary, which is that of a first lieutenant, even though they know they can't get a raise in rank or in pay, and work for us on that basis. We wanted to pay people more so that we would have more to

offer. At the present, cost-plus contracts of the Army which pay 6 to 10 thousand dollars for industrial medical doctors are a little too tough for us. We had to pay them a little more than we were, anyway, and I think, in a very short time we will have Job Classification Sheets for industrial civilian physicians which will be accepted by the Civil Service Commission Civilian Personnel, ASF, and others allowing us to put doctors in those particular grades.

As to the question of absenteeism in industry, it has not proved feasible to have visiting nurses go around and check up on Johnnie Jones when he does not come to work. That has been the experience of a lot of insurance companies and other companies. We have heard that in the Army, and we have asked those who have used that system to send us the figures proving it and we never received the figures.

We think that's pretty much a waste of personnel. We do think that you will clear up your absentee cases through Industrial Dispensary before they go back to work. You will find that will have almost the same effect and that it can be done. As far as employees of the Transportation Corps or other Corps that do not fall within the Adjutant General's definitions of an industrial worker in Army owned and operated industrial plants, arsenals, and/or depots, we are very sorry we can't give you more information.

LT COLONEL COREY:

That has answered my question very well. I would like to come back to the first one again a little more directly. Would it be sufficient if a directive were to be issued from the Office of the Chief of Transportation saying that in the future, all pre-employment medical examinations would be done by the Industrial Hygiene organization? In other words that the Civilian Service Medical certification form is within the scope of what you feel is the industrial hygiene ideal.

LT COLONEL COOK:

Yes, I could say in many of the arsenals and plants throughout the United States they do their own physical examination of every civilian employee that is hired and they do not follow particularly the Civil Service form because many of the doctors feel that it is inadequate and doesn't give them enough information; for example you take only blood pressure, you don't do urinalysis of those women over forty or forty-five. They don't have to have certain examinations for urinalysis or blood pressure taken just because they happen to be females. We believe both females and males can be sick. The extent of your program depends entirely on the man doing it and how much authority you will give him and how much help he has. I can show you excellent programs and poor programs probably right within a very few hundred miles of New York City

LT COLONEL FARR:

Thank you Major. Are there any other questions? We will continue with our schedule now. With the prospects of increasing the number of inbound personnel which includes not only military personnel but also civilian personnel, the problem of preventing the importation of diseases becomes one of our major problems. We have with us this afternoon two officers from the Surgeon General's Office who are quite competent to speak on this subject. The first one will be Lieutenant Blanton of the Sanitation Branch of preventive medicine, who will discuss the status methyl bromide facilities. Lt Colonel Lundeberg, Chief of the Epidemiology Branch of the Surgeon General's Office will give a further discussion on the problem. We also have with us today a Mr. Latta from the U. S. Department of Agriculture, Bureau of Entomology, who I believe has a great deal to do with working on some of these projects, and Mr. John Wolf of the Office of the Chief of Engineers who has a great deal to do with the design of these disinfestation units so if you have any questions at the close of this period, I think that we are in very good shape to get them answered.

LT BLANTON:

By way of introduction, let me say that M.B. (note: hereinafter indicates methyl bromide) is really the answer to the entomologist's prayer. It has an uncanny ability of penetration and many of the other fumigants fall short of some of the characteristics of M.B. I would like to mention just one example where it has proven its worth. It happened to be my pleasure to be working out a control of a serpentine leaf miner, who was mining in between the two layers of thin leaf of a very expensive green-house plant. We tried everything we could, but found that the plant was just a little less to tolerate than the insect. Finally, I hit upon M.B. and through its quick penetrating quality, we were able to eliminate this post from a large eastern green-house ranch.

A long list of a great many insects that other controls were incapable of curbing succumb to M.B., which did the job in good order. About a year and half ago, representatives of the Surgeon General's office called in the Bureau of Entomology Plant Quarantine of the United States Department of Agriculture to conduct some experiments with various fumigants hoping to find something that would replace steam. Well, after trying chloropicrin and a number of things like cyanide, they hit upon M.B. They thought at that time that it would be equally as efficient as any of the other fumigants. That was chiefly developed for field use. But then as you Port Surgeon's know, with the incoming prisoners, it had to be used, and they had hopes of using it for that purpose. But then weeks ago, I was called into the Surgeon General's Office to join a malarial survey unit with prospects

of going to New Guinea, and was told at the time that some of the Ports were having a little problem with their M.B. Fumigation Chambers. I visited four ports in the East and I also visited factories at Hagueston which made some of the prefabricated chambers and also Camp Lee, Va. which has some of the plywood and prefabricated chambers in use there. Well, the only time I visited Boston, they had a nice set of blue prints. They do have plans for 450 or 500 man per hour disinfestation plants and they're going to use concret chambers, I believe. Every port you might say, presents a different problem. Some ports have too little space to carry out the regular plan that was drawn for disinfesting plants. At Boston, they will have to use two floors. They're going to have to use chutes to send the clothes down to the fumigation chambers. Also by the use of concret which is quite heavy, they can't put the chamber on the second floor and naturally, it had to go on the first floor.

New York had its headaches as Colonel Melton and all of you know there is a beautiful plant on pier 84 mostly steam, but it is built so that the fumigation chambers, when satisfactory chambers are available, can be installed in place of the steam. I have seen plywood chambers and concret chambers, submarine net buoys converted and also prefabricated chambers. I am glad to say that I never saw the plans of those original things because at least we might be able to accuse some poor carpenter for turning that out and not placing the responsibility on the designer. I might say that the biggest fault with them was the felt gaskets. Unfortunately M.B. does not know anything about the shortage of rubber and it goes right through felt. No matter what kind of chambers you build or buy, the size of the door depends on whether you want to use trucks or not. Smaller doors - you can't get small trucks into them, but with large doors like you see on this model here (indicating) you can get a truck in that carries from 60 to 80 bags - push it all the way in - the trucks being loaded prior to the treatment.

I came to New York once and saw very small trucks that had 16 bags on them. I saw three men work 7 minutes to get one of these trucks into the chamber. That was the longest time it took I will admit, but there was something wrong with the design of that truck. I didn't know at that time, but I thought it was the fault of the trucks and I was ready to condemn every truck until I went to Charleston and there they had one which was much larger and differently designed, and held 81 bags. Two men were pushing it around and they pushed it into the chamber within two minutes. One of the most important features about any fumigation chamber, is the door and the important feature about the door is the gasket, and how it should be installed. It seems that it is very hard to get gaskets particularly the kind of gaskets that should be used. There should be always two gaskets. Don't let anyone tell you differently. And those gaskets should be cut on the square.

they should be beveled and should never be cut on the corners; notch them and bend them around. Then thenext thing is hinges. A lot of the places have hinges upon which they depend to hold that side of the door against the gasket. That never works. It may work for a week, but it is no good. It should be a loading hinge and should have separate fasteners to clamp the door to the gasket after the hinge has pulled it around in place. Fasteners for the door have always been too few at most places and in many cases too light. It does not take too much pressure though, just so that the pressure is even on the gasket. Now I will mention some of the hazards. M.B., like any other fumigant that is worth anything, creates hazards if it is left around the operating personnel who will breathe it in over a long period. It is just as dangerous to have a low concentration over a long period as it is to have a high concentration over a short period. Most of these hazards have been due to leakage from the poor gaskets on mal-fitted doors, and to leakage around the applicators, that is, the measuring devices. These devices are an easy thing to check and the people who install them are glad to give instructions or, at places near them, will be glad to check them for you and install them.

Another serious hazard is gas in the dressing room. This is caused by pulling the bags before the gas is taken out, and I assure you it is pretty hard to get them out of the bag. Now we are working on a plan that under preliminary tests enabled us to get out 80% of the surplus gas at the end of the fumigation according to our leak detector measurements which are quantitative in nature. We hope to do some additional experiments and use qualitative measurements, but even so, in those tests after we had taken the major part of the free gas out, we took some of the clothes out and put them on the hood of an automobile where we left them for 58 minutes. We put them back into another bag and we still had some gas coming off - not much, but a little. That shows that woolens hold on to the gas for a long time and that we're going to have to have adequate ventilation in the dressing room.

At one place, the ventilation was poor and there was a considerable amount of gas in the air. A test of the blower which was supposed to be taking the air out of the dressing room and changing the air - was not able to affect my handkerchief when I hung in front. We were told that the reason for that was that the window was left open. Personally, I can't see that. I found that where two blowers were being used on six vaults of 265 cubic feet to get the gas out of the vault, one of those same blowers was being used in a dressing room of 28,000 cubic feet. It is up to the ventilation experts to put adequate ventilation in the dressing room.

Another thing I would like to mention here is the way exposure periods are set up based on treatment in the vault. Circular No. 99, Section 2 on Page 3 of that Circular, there is a schedule of exposure depending on the temperature. I should like to call to your attention at this time the fact that the temperature should not be based on the temperature of the clothing or of the woolens. The insulators should be good and if you put cold woolens into your chambers be sure that you place your dosage in the exposure end according to the temperature of those woolens, otherwise we will have lice escaping. At this time I would like to introduce Mr. Randall Latta, who was one of the original workers on the list of the Surgeon General's Office and had a great deal of experience with methyl promide in this country, in Puerto Rico and Havana, Cuba in experimental stages and also with large commercial treatments.

MR. LATTA:

This problem of fumigation was turned over to the Bureau of Entomology because of the experience we have had in the application of fumigation methods for the control of insects. Our Bureau instigated the original work of developing fumigation at atmospheric pressure. At the request of the Surgeon General's Office we have developed not only the method of fumigation, but the equipment with which to apply this method. The desire was for equipment that was simple, light in weight and made of non-critical material and that would efficiently do the work. We developed two things, a fumigation vault, a model of which we have here, and the individual fumigation bath. The vault after it was turned over to the Surgeon General's Office for testing on a large scale has passed through many hands, many innovations and ideas have been added to it. In fact, so many that little Abner would say "It's getting a bit confoosin". So today I thought I would take this opportunity to show you the original model and the basic simplicity of it in a discussion of the basic fact of fumigation, so that when these problems of equipment come to you, you can evaluate the merits of the changes that are made in the equipment on the basis of what you know to be necessary in the first place.

The original vault was made of half inch plywood with two-by-two supporting frame which was designated for a field unit and which was demountable to be taken apart and transported in trucks. It consists of six panels--buttom, top, two sides, front and back. The front was used as a door and the gaskets seated on the face of these panels and the door fitted in this manner (demonstrating on the model). It can

be hinged with the light type of hinge if you wish, or it can be set in by hand which is the method now used in the model built by the QMC. The type of fasteners is also a cause for quite a bit of discussion. That is really a place for a field day with man's inventive mind, because you can figure as many types as there are men working on the problem. But the basic thing is that you want to fasten the door against the body of the vault so that the gaskets seat evenly. It is not necessary to have a heavy, rigid door. If you have very few fasteners, such as refrigerator hinges on one side and refrigerator type clamps on the other it is necessary, of course, to have a very rigid door so that it will not bulge between this point and that point (indicating the frame of the box where the door is situated on hinges). But if you use a light type door and put in enough fasteners, it is just as good. It is between this point and that one (indicating front end of the model) that the rigidity of the door matters. We have advocated all of the time a double row of gaskets around all of the openings. The primary factor in a fumigation vault is that it must be gas-tight. In this case you have rapid circulation of the gas within a vault. You have only a short time period so that a leak factor can upset your calculations. One gasket will work for a while, but two gaskets can do six times a better job. One seems to protect the other - they last much longer. They have on commercial installations - - lasted 3 or 4 years. If there is an uneven place on the seating of one gasket, the second gasket tends to protect it. We have tested that in many ways and have come to the conclusion that the double row of gaskets is necessary on all openings, especially the small ones and that is the point often overlooked. You see the small vent in the front door has this double gasket (indicating). The vent inside here - these are the gaskets. This simple arrangement has worked out whereby one blower can be used for the circulation within the vault and the venting of the gas afterwards. In this method if you can see inside of here (indicating inside of the box) there is a directional duct up the back wall at which end you just blow through the vent. When the vault is in operation, the exhaust vent is closed so that the air circulates within the vault. When it is desired to operate it, the operator without any hazard to himself, at the rear of the vault pushes in the rod here - that has a fastener and that closes the damper directly over the top of the duct diverting the air up through the exhaust duct so that it can be piped out. You see how the rod actuates the damper (demonstrating operation of the rod). As I have said, there have been many ideas added to this equipment.

The Quartermaster Corps with a field unit has designed, I think, about six types. They have gone around in a complete cycle and have come back to a type basically like this: (indicating). There has been considerable comment on the use of plywood; it would be easily injured; the setting surfaces between the panels would be injured, so that you couldn't make a tight seal. Well, the answer is, the fumigation vault is not apt to be of rigid structure. We have then made out of the framed, covered with a gas-tight cloth material which has worked very well. In this case, your plywood contains gas enough to do a good job. The setting surfaces are sealed--each set is sealed up by a compound and seals up the panels all around with his fingers. He shuts the door and tests it by looking all around. He can see where he has done his work and he therefore can do a very good job.

The type vault designed by the Army Engineers has all the basic ideas of this, except it is a bit heavy. It is made out of concrete and it has a heavy steel door. It has a circulation inside the vault and a gas type chamber, which are all contained in those plans. I have samples of the dispenser, but I think all you gentlemen are familiar with it, at this time.

(At this point Mr. Latta produced the dispenser and demonstrated its operation)

You tighten this clamp and it releases the gas into the vault.

I also have samples of the type of rubber gas fitting which we have used very successfully if you would like to see that, and I am quite willing to answer any questions that I can following this, I thank you.

LT COLONEL FARR:

Thank you very much Mr. Latta, Colonel Lunderberg, do you want to go ahead?

LT COLONEL LUNDERBERG:

It is getting late and I will try not to detain you gentlemen longer than the appointed hour. The problem of what to do about the returning soldiers of course is now upon us, and it will be increased when the rotation plan gets into full operation. We in the Surgeon General's Office have just recently heard about the rotation plan. I believe it was mentioned in this conference yesterday. The problems will be multiplied enormously during the demobilization period. No one knows as yet what the temp of demobilization will be. It

may be reasonably slow and orderly, or it may be speeded up by public demand for the rapid return of tired troops, anxious to resume civil life. No matter what the official speed set by the War Department, I think it is reasonable to expect that the processing of troops through ports and through demobilization centers will also be attended by cries for greater speed. This is certainly the experience of the last war.

The rotation plan proposed by the War Department fortunately offered us the opportunity of a training period in demobilization. It is true that the demobilization is only partial and consequently many corners can be cut to save time. This is very fortunate. We hope to see the present plan of handling returning troops evolve gradually into an efficient and workable scheme for mass demobilization, which will inevitably come.

The present plan contemplates a rather rapid passage of troops through the Port areas with a stay of two to four days, in so called reception stations. From one to three stations will be designated in each Service Command, utilizing the facilities of well-established posts. From the information now available to us, it appears that the bulk of the processing, both medical and otherwise, will be done at these reception stations.

Before going on with the discussion of the present tentative plans, I would like to consider briefly some of the medical and public health implications of the problem of the returning soldier. There has been a great deal written about this. They have written about it in the public press and large numbers of dire predictions have been made about it. The problem presents two important aspects. One, the protection of the individual soldier, who is returning. At the moment I would like to confine my remarks to the period of the next few months when this rotation plan is going to be in effect. In considering that, we should bear in mind the following facts, which bear on this aspect of the problem, and which really must be given careful consideration. First, we have to acknowledge that troops from some areas will have been heavily exposed to malaria, dysentery, and other tropical diseases, and high infection rates may be expected. I think there is no denying that. That is a hard fact that you will have to face. Secondly, the troops returned on rotation are returned because they are fatigued by long residence in war areas. Many soldiers will definitely be under par, physically. There will be many sick cases. Thirdly, all will be eager for furlough and the time for examination will be short. You can imagine the pressure that will be brought on you to let the fellows get by. They are going to want to get home quickly. Next, some tropical diseases resist treatment and are prone to relapse. This is true of malaria, filariasis, schistosomiasis, chronic bacillary and amebic dysentery. Five, some civilian physicians may not be

acquainted with the exotic tropic diseases, and failure to diagnose and properly treat cases may be expected. Lastly, for the present, troops will return to military control after a furlough and will again come under medical surveillance. That is the saving aspect of the problem at the present time. This fact simplifies our medical problem enormously. We will not have to check and record the present physical conditions against the condition at the time of induction. For the majority of troops, our chief concern will be to see to it that the individual will be sufficiently fit to be turned loose in his home community for a few weeks furlough.

The other side of this problem is the protection of the public health. That is the thing that agitates people more than anything else. There you have to consider the many arguments brought up on this subject one way or the other. Some Jeremiah has predicted catastrophe - the country over-run by malaria and dysentery and all sorts of dreadful tropical diseases. One of the things always mentioned is the possibility of the establishment of endemic foci of diseases not now present at a given area, and of course, malaria, is the main one, which people are worried about. Filariasis -- have had some filariasis among our troops. Then we can speculate about schistosomiasis and onchocerciasis, trypanosomiasis and leishmaniasis. These typical tropical diseases occur frequently in Central Africa and down throughout South America and the Far East.

People are worried in addition to that about the introduction of new and virulent strains of diseases that we may have at the present time, but are held under control. An example of that would be the introduction of a very dangerous type of malaria. Next, there is worry about the introduction of new and more efficient vectors of diseases, such as anopheles gambiae. Our friends interested in the agricultural aspect of this are worried about the introduction of new agricultural pests, such as the Japanese beetle, and this thing that eats up the cotton down South. I don't know much about those. All this is very important also from the economic point of view. The possibility of yellow fever exists and our old friend the louse -- the typhus louse. A louse gets loose from a prisoner and gets on to one of our Americans.

Another worry is the introduction into the community of a large number of infected individuals who, by mere might of numbers, might be capable of initiating and propagating epidemics; that is the thing people are worried about. In this group, you might place such diseases as amebic and bacillary dysentery, trachoma, hookworm disease, and possibly relapsing fever.

In the face of all that the bad predictions that have been published and spoken of in public--these questions arise. What is the Surgeon General's Office going to do about it? What is the War Department going to do about it? What is going to be our attitude towards this thing? It would be very nice if there were some men wise enough who could see into the future and who were really wise enough to know what to do about it. Certainly there is nobody in the Surgeon General's Office or in the War Department who is that wise. We have done the best we can. We have consulted all the wise men in the country. For the past year this thing has been mulled over and discussed, and thrashed out by the wisest men in the medical profession and the field of public health. The experts in the Surgeon General's Office, and the experts in the National Research Council have had repeated meetings and the thing has been thrashed out from every possible and conceivable angle. We do have a certain tentative plan which has been worked out. In other words, we have taken some sort of a stand. How wise that stand is going to be we don't know yet. It will soon show whether it is adequate.

I want to give you a rough idea of what the point of view, of the War Department and of the Public Health Service, and of the National Research Council is on this problem. In July of this year at the numerous meetings and at the request of The Surgeon General of the armed services, the National Research Council gave us their considered opinion. They told us what they thought we should do in the case of certain diseases. They also gave us their explanation of what the magnitude of the problem was and the seriousness of it.

I would just like to read from the official minutes of that meeting. I will go to the back of the thing first and pick out the real pest -- the plagues. It mentions plague, cholera, yellow fever, typhus, smallpox, leprosy, anthrax, psittacosis. Those diseases are the so-called quarantineable diseases, officially declared so by the Public Health Service. They are really bad diseases. Ships coming into this country from ports where those diseases are present have to have Bills of Health, I think it is called, and inspectors and quarantine. Our advisors have told us that it is their considered opinion that present quarantine regulations, if meticulously carried out, are considered adequate for the protection of the country from those diseases. There isn't time to go into that any further.

The next group of diseases are not quarantineable in the same sense: Bacillary dysentery and amoebic dysentery. A lot of people are worried about that. I don't know why because we have plenty of dysentery in our own country. Trachoma, Loa-loa, relapsing fever -- louse-borne and tick-borne -- and oroya fever have been put in a separate category, and it seems to be the feeling of the wisest men in the country that the chance of

establishing through debarkation endemic foci of these diseases in this country were negligible, or that no preventive measures were feasible.

Now then, Leishaniasis and Trypanosomiasis -- it was recommended that men diagnosed as having Leishaniasis and Trypanosomiasis be hospitalized and treated until cured and rendered non-infectious, if practicable, and this is not a very difficult job.

Ondhocerciasis -- we may have a few people with this disease coming back and it has been recommended that no further attention be paid them, except to remove the nodules.

Schistosomiasis -- there is a considerable amount of concern about that. The National Research Council advise that all known cases be hospitalized and treated until cured and rendered non-infectious if that is practicable; that studies be undertaken to determine whether local species of snails can act as vestors and to develop more satisfactory drugs for treatment. That is being carried on now by experts of the Public Health Service and others. They recommended also that the Surgeons General of the Army and the Navy make available from their records upon request of the United States Public Health Service, the names and home addresses of all military personnel discharged to civil life who have a diagnosis of Schistosomiasis. We are not going to set up an elaborate system of reporting the diseases which will probably be as rare as that. From the available records -- from the Form 52 that comes into the office, it will be possible to know at all times the names and addresses of those individuals, which can be turned over the Public Health Service for surveyance.

How then for Filariasis -- the following recommendations were adopted:

a. That men with symptoms of filariasis be hospitalized until clinically free of the disease. Filariasis really is a chronic disease and we have no specific cure for it. It lasts for years and the only good thing you can say about it is that it doesn't increase -- The diesease doesn't progress -- once the man is removed from the danger of infection, but it is going to be impossible to hospitalize every man until he is cured. It may take years.

b. That when feasible men diagnosed as having filariasis, be evacuated from endemic areas.

c. That infected men are not to sent again into endemic areas.

d. The presence of microfilariae in the blood in the absence of clinical symptoms shall not warrant restriction on the movements of the infested individual except as noted in recommendation c. above.

e. That the Surgeons General of the Army and Navy make available to the United States Public Health Service from their records, upon request, the names and home addresses of all military personnel discharged to civil life who have a diagnosis of filariasis.

f. That further studies be undertaken to determine the ability of local species of mosquitoes to act as vectors of filariasis and to discover effective drugs for treatment.

Now for Malaria, which is the "bugaboo", the most important of all, and is really a problem. The recommendations we have on that are as follows: One, that military personnel not be discharged to civil life until sufficient treatment has been given to render them clinically free of the disease. Two, that encouragement be given to programs for the control of the mosquito vectors in known and potentially endemic areas in the United States as the most practicable solution to the problem of preventing postwar malaria epidemics. Three, that every effort be made to provide the quantities of antimalarial drugs necessary for civil use.

In general the consensus of opinion was that the rigorous enforcement of present quarantine regulations and the efficient application of measures now in force to prevent the importation of new disease vectors would afford adequate protection against the introduction of the majority of tropical diseases.

General recommendations regarding the introduction of tropical diseases into the United States were as follows: One, that the efficacy of measures now in force to prevent the introduction of disease vectors into the United States be investigated by the Interdepartmental Quarantine Commission of the Army, Navy and Public Health Service and that changes be recommended as indicated. Two, that through the medium of medical journals physicians and health officers be repeatedly admonished to consider the various tropical diseases, particularly malaria, in any discharged military personnel coming under their care. Three, that measures be taken to instruct medical technicians and personnel of public and private diagnostic laboratories in the United States in the diagnosis of tropic diseases particularly malaria.

Now we have here the opinions of experts which might tend to lull one into a sense of security and I think that would be entirely wrong. The problem is going to be grave, there is no doubt about that. I don't believe there is time to go into ------(turning to Lt. Colonel Farr) how much time do I have?

LT COLONEL FARR:

Twenty minutes.

COLONEL LUNDEBERG:

I would like to take ten minutes to abstract from a paper read this morning by Colonel Russel McCoy, dealing with this very problem. I think it reflects pretty well the official view of the War Department at the present time. Colonel McCoy summarizes the three important points of the Public Health aspects of diseases as follows: One, the possibility of establishing new endemic foci of the disease in areas now free from malaria. Two, the introduction of new strains of the parasite in regions where malaria is already present, and a resultant increase in the amount of malaria in these areas. Three, prompt recognition and proper treatment of relapses in soldiers after they have returned home on sick leave or furlough or have been discharged from the Army.

The first of these problems, that of the possibility of establishment of new endemic foci has attracted the most attention. Exaggerated statements predicting dire consequences have occasionally been published in the public press. Suggestions have been offered that Troops returned from malarious areas should be segregated. In the north the point of view is that such troops should not be sent to northern states because these sections - malarious 100 years ago - are now freee from malaria and the disease should not be introduced again. In the south the opinion prevails that infected troops should not be brought to southern states because in this part of the country conditions are most favorable for the spread of the disease. There is some merit in both points of view, but questions may be raised as to whether either of them is really valid. It does illustrate human nature a little bit though. The idea of "let somebody else look at it".

The practical difficulties of segregation are, of course, obvious. At present there are no certain criteria by which a case of malaria may be pronounced completely cured. Relapses may occur after many months of latency. It would certainly be impractical to attempt to deny furlough to returned soldiers for any such length of time. Since the discovery of the mosquito transmission of malaria at the turn of the century, it has been demonstrated repeatedly that the most fruitful methods of malaria control are those directed against the mosquito vector. Methods designed to control the human reservoir of the disease are of decidedly lesser importance. In this country the

accepted line of attack against malaria has been that against the mosquito vector. No attempt has been made to control the movement of human carriers of the disease. I believe a little reflection on that will show it to be the case. Up until the last decade thousands of infected immigrants from southern Europe were allowed to enter this country and to settle at will. Seasonal migration of southern agricultural workers of northern states has been encouraged in the last 20 years. No untoward consequences in the malaria situation have resulted from this policy. There seems no good reason to take a different attitude toward soldiers who may be carriers. As long as a soldier remains under military control, there should be slight chance of spread of malaria to civilain communities. The men live in well-sanitated camps. When sick, they receive prompt medical attention. Proper screening of hospitals should prevent them from being bitten by mosquitoes during periods when gametocytes are most numerous in the blood.

The chief problem arises after soldiers have been discharged from the Army or return home on sick leave or on furlough. When relapse cases occur in communities where there are anopheline mosquitoes, these individuals may be a source of spread to others. It is well to consider how serious this danger is apt to be. Outbreaks of malaria have occurred from time to time in one-endemic areas in the northern United States. In recent years there have been such outbreaks in southern Minnesota, eastern Iowa, northern Ohio, and in Camden, New Jersey. In the summer of 1942, a small outbreak, involving ten cases, occurred at Wappinger Falls in the lower Hudson Valley of New York. This past summer, a somewhat larger outbreak of 53 cases occurred at a small town in Illinois. The characteristics of these outbreaks are much the same. They have involved comparatively few cases, they have not tended to spread, and often have subsided without anti-mosquito measures. Unlike dengue, malaria does not tend to occur as an explosive epidemic. Even in localities where conditions are favorable for spread, the warning given by prompt recognition of early cases ought to allow the institution of control measures to prevent an extensive epidemic. It would appear reasonably certain that prompt action to control Anopheles mosquitos will be sufficient to prevent serious trouble from any new foci of malaria which may occur. Where local authorities do not have the personnel, supplies or equipment to conduct anti-mosquito work, the United States Public Health Service, with its special organization for malaria control, is prepared to give immediate help when asked to do so by the state department of health

Another aspect of general problem is the possibility that new strains of malaria introduced might be more virulent than those already present in this country. Although differences in virulence may occur, they apparently are not of sufficient magnitude to be of great significance. In recorded epidemics of malaria, it has always been some change in the mosquito population that has been responsible. For example, in Brazil some years ago it was the introduction of a new vector, Anopheles gambiae, which is a more potent carrier than the species of anophelines normally present. In the Ceylon epidemic ten years ago it was the exceptionally great increase in the number of anophelines already endemic. Over 90 percent of the relapsing cases of malaria among returned troops are of the vivax or tertian type. This species of parasite is much less apt to produce malignant infections than is Plasmodium falciparum, the subtertian or estivo-autumnal parasite which predominates in the tropics. Although it is more difficult to effect a permanent cure of Plasmodium vivax infections, this species can be considered less dangerous than Plasmodium falciparum as far as introduction into this country is concerned. In the past the most serious epidemics of malaria have always been caused by the falciparum parasite.

Probably the most important problem concerned with the return of infected troops has to do with the individual soldier himself. Will there always be prompt recognition of malaria relapses in soldiers after they have returned to their home communities? In many sections of the north, physicians are not familiar with malaria, especially the estivo-autumnal type caused by Plasmodium falciparum. Failure to make a promot diagnosis may be a serious matter in cases of malignant malaria. Prompt diagnosis of malaria cases is not only important to the patient, but is also important for the timely institution of control measures if outbreaks of malaria should occur. Now I have taken the time to read that abstract of that paper, which I think will probably be published somewhere soon, because I believe it summarizes the point of view of those of us in the Surgeon General's Office and of our advisors.

Now I think I should mention at this time a little bit to give you some idea of what the present plan is or the tentative plan for the handling of these returning troops, troops coming back on a rotation status. That is the thing I spoke of a short time ago. At the present time there is a form in development, a War Department Circular, which will direct in a broad way what the functions of the Medical Department will be in handling these returning troops, and secondly, there will shortly be published a technical circular

letter from the Office of the Surgeon General, giving in some more detail, an outline of what is conceded to be an adequate program for the handling of these returning troops. You all think immediately, of course, of the question - how elaborate an examination do we have to make? Is it necessary to do laboratory tests on all these troops for all these diseases? As I have indicated from the abstracts from the National Research Council program there, we don't feel that it is necessary.

Tentatively, this is what the Surgeon General proposes. We are going to attempt by some means or other to get a general history back of the troops. That doesn't mean a medical history or a long detailed statement, but we must have some information as to where themen come from and a little bit about the types of diseases to which they have been exposed, and if possible, the amount of tropical diseases and other communicable diseases they have had in the past few months. In other words, anything about what these troops have been exposed to will forewarn our medical examiners what to look for. Just how this information will be obtained isn't known yet. However, some sort of medical history will come along with these people. It is planned that at these reception stations, as I think they are called, of which there will be some 12 or 14 scattered throughout the country, the men will be sent in groups for processessing before going on furlough. A check will be made on the history of the infection in the group or the individual. Each individual will be examined medically as expeditiously as possible.

I might read this and then I would like to have your comment on it. "General Medical Examination. Each individual will be examined medically as expeditiously as possible, not following routinely a plan for complete physical examination, but giving special attention to manifestations of conditions considered most likely to be present as the result of his foreign service. The diseases considered to be of particularly importance at this time include those mentioned in par. 5, below. In addition, careful consideration will be given to the possible presence of unrecognized neuropsychiatric disorders.

5. Special Medical Examination. If the available history or the general examination indicates the possible presence of one of the diseases listed below, the indicated special examinations should be performed:"

I have here a half a dozen diseases which I will mention. Amebic Dysentery. - It has been proposed that if the man had a history or suggested symptoms or physical findings of

amebic dysentery, a certain amount of laboratory work will have to be done. In the case of amebic dysentery, it will be the examination of fresh stool smear. In the case of bacillary dysentery, an examination of the stool culture and smears. Filariasis should be easy to diagnose because most of the troops will not come from where it is. Careful examination of the lymphatic system and scrotal contents. Blood smear for parasites. You never recover many parasites on these early cases.

Hook worm. In some places in the South Pacific, there has been more hook worm than was anticipated. It might be well to check into that a bit by use of the stool smear.

Now then, malaria. There must be a physical examination, sufficiently detailed to determine the presence of significant effects of chronic malaria a thin blood smear -- this should be done routinely in men who have discontinued the taking of suppressive anti-malarial drugs within 30 days. You can't turn men loose for three or four weeks, or however long the furlough is going to be, without trying to estimate whether or not he is going to have a relapse when he is home. There must be a detailed examination to really determine his condition. Pulminary tuberculosis - chest X-ray examination in all suspected cases. Schistosomiasis -- stool and urine examinations for ova. Trachoma -- careful inspection of conjunctival surfaces. Venereal diseases-- inspection for evidence of infectious cases - dark field examination, blood serology, smear and culture for gonococci, when indicated.

Hospitalization should be provided for men in whom the following conditions are shown to be present: Amebic and Bacillary Dysentery, Hookworm Infestation, Schistosomiasis: Treatment until the patient is cured or rendered non-infectious. Filariasis with Symptoms: Hospitalization until the patient is free of symptoms. Clinical Malaria or Malarial Parasitemia: Treatment until the patient has been free of symptoms for two weeks and/or two negative blood smears have been secured. Probably something should be done or will have to be done about warning the man who may come down with malaria. Give him some warning. You can't turn them loose without some warning about what they might possibly expect.

In all other diseases - no mention is made of all the thousand and one other diseases these people may have because they are pretty well covered in other existing regulations. I wanted to read this draft of the proposed Surgeon General's Office Circular letter. It will give you an idea of what is being thought of in the Surgeon General's office, and it will inform

you of something that will probably come out eventually. It will take a lot of coordination with other agencies; transportation and personnel and the other ones.

LT COLONEL FAIR: Are there any questions you would like to ask on this particular subject at this time.

(No Response)

It not, thank you very much Colonel Lundeberg.

We now have a few minutes scheduled for open discussion on subjects that have come before us. However, before we enter into this discussion, Commander Terwilleger has indicated he would like to add a few remarks for the record.

COMMANDER TERWILLEGER: I enjoyed the reputation of being a man who spoke off the record; I will now speak on the record. Colonel Melton, about a month ago, mentioned that members of the crew aboard the ships were not willing to submit to physical examination by medical officers of the Army, and that question was brought up again yesterday by General De Witt. This morning I checked with the Division of Operations and they are working on that. We can hurry it up if we can get a formal request from this meeting asking that a directive be issued along these lines. Send that to the Deputy, Administrator of War Shipping, addressed to the attention of Mr. H.W. Jackson.

The second point raised yesterday was ships operating under War Shipping Administration, that they only were allocated one way. On the return voyage it was decided that these ships would carry patients. One criticism of the ships was that they were not adequately stocked with food, nor did they have proper personnel in the galleys.

If we review the regulations in regards to that, all ships allocated under War Shipping Administration are given a sufficiient supply of food for a return voyage plus 30 days. When the ship is in a foreign port it takes on rations for the crew, for the stevedores, and for the people operating in that foreign port so that there should be no need for the waste of food. In regard to the personnel of the galley, it is the obligation of War Shipping to staff that galley with people in key positions like the storekeeper, the chiefs, etc., bus boys, scullery men, etc. If the staff is inadequate then that would be supplied by the Army Transportation. I just want to clear up these three points of yesterday.

LT COLONEL FARR:

We have here, as I mentioned before, Mr. Wolfe, from the Corps of Engineers. I wonder if you would like to say a word about the progress that is being made on the design and construction of our disinfestation plants.

MR. JOHN WOLFE:

The concrete chamber which we have developed incorporates all the features which Mr. Randall Latta pointed out, in his pre-fabricated model here, with the exception that we have made it out of concrete. I have been up to the manufacturers of the doors to talk over whether or not the contractors can secure them when these particular boxes are made. This outfit is perfectly willing to make doors providing a sufficient number of them are needed. I gave the name of the President of that company to the Division and area Engineer Officers, whereby they can contact them in the event that they wish to use pre-fabricated doors.

LT COLONEL FARR:

Thank you Mr. Wolfe. Are there any further questions now? We have got to start on some one point on these q uestions. Let's take this last one we just discussed - the one Mr. Wolfe just discussed. Does anyone have any questions he wants to raise on disinfestation plants? Their progress or design?

COLONEL LUNDERBERG:

I would like to ask Mr. Latta about the time it requires to kill a louse in the ordinary delousing processing with B.M . What should we tell people who see a louse is still alive when he comes out of the bag?

MR. LATTA:

That will depend on the amount of over-dosage. However, they should all die, I would judge in from two to six hours. It is possible that there might be some activity after 24 hours but that is rather rare. They do not feed and if the eggs are removed from the female, they are not viable. About the direct ratio to the temperature of the increase of the dosage, that is, the more surplus dosage you have the quicker they will die - that is variable and will depend on conditions. I have examined a good many hundreds of men - and I have yet to see any visible symptoms. I don't believe there would be much chance to see anything. The activity immediately following the fumigation ceases very soon. When we talk about death, we mean no activity, even when the insect is disturbed.

LT. COLONEL FARR:

It is possible, is it not, that some of these dead lice will fall off the clothes and what not into the trains when they are being moved, and someone is going to raise the question. We say a louse is dead, what can we tell the railroad people if they have occasion to say "You fumigated these people, but we found some lice". We would be assured they are all in the proper state?

MR. LATTA:

I think the chances of that happening are very slight. The lice do not stay on the body, they stay on the clothing. Even though they have been killed, they tend to cling to the clothing. They are practically always on the inside of the underwear, or in the inside of the shirt, next to the body where it is warm. Personally, I don't think there is much chance that one will fall off after it has been fumigated. As long as there is any activity, the one that did fall of would be a dead louse.

COLONEL LOWRY:

I would like to ask a question on that. Is there a practical point to which you can raise your methyl bromide dosage and kill them outright? Apparently there is a psychological effect on these people if they find one falling off.

MR. LATTA:

I don't believe so within any reasonable limit, but I can't say. Already we are working on a very high dosage in a short period, which is much in excess, to be used for our purpose. If you double your dosage, still I don't believe you can shorten that time a great deal more. Even with humans if you put a warm blooded animal in a terrific concentration of methyl bromide, your action is secondary and the process still has to take place.

COLONEL REXROAD:

I would like to raise this question. Why do we bring the louse over here to kill him rather than kill him on the other side.

LT. COLONEL FARR:

That is a very good question, and I note the Second Service Command has somewhat the same question. The present practices I believe are that they will

be deloused on the other side. Colonel Lundeberg can you give us an inside as to what that directive is going to be?

COLONEL LUNDEBERG:

According to the present directives the delousing of all prisoners of war is on the other side, and I think the prescribed delousing of all infected individuals. I think one very good answer to your question is that it is easier for your people on this side who are working under conditions where delousing is much easier than over there. That is one thing. Troops from North Africa when the fighting was over there -- the facilities and opportunities for doing a good job of delousing were not so good. The question really is valid and I think the delousing has to be improved, but I don't know how good the job is. All prisoners of war are deloused abroad, and I think the way it stands the people abroad are charged with delousing everyone who is lousy before he comes aboard. I believe before we are through with this debarkation of all troops, we are going to find an enormous amount of delousing to be done aboard ship while enroute.

LT COLONEL FARR:

Do we have any further questions?

COLONEL HARDENBERGH:

Colonel, there are a lot of experiments still going on in connection with delousing. We are considering impregnating clothing. That is still in the process of investigation, but we cannot say, at the present time, whether we will adopt that sort of thing or not. That may be the answer to the Colonel's question.

COLONEL MELTON:

We have had some experience here, actual experience, in receiving prisonersof war. That experience was with the wooden disinfestation chamber -- we filled twenty of them -- it cost $20,000. We put clothes in there and after we withdrew them, we found the lice alive. We got samples of lice and eggs from the Rockefeller Foundation and put them in there and it didn't kill them. It is much easier to kill a louse than the egg. We have operated those in every conceivable manner I think, increasing the amount of gas, and increasing the time of exposure, etc.

I have a record of all of those and if we have time tomorrow, I would like to have my officer bring those up and

show you exactly what we found. These prisoners we have, have been deloused as many as 6 times, some of them, and practically all of them have been deloused successfully with the exception of some we got back three or four months ago. There is a certain percentage of these individuals still infested with lice when they get here. I think part of that is due to the fact they don't kill the lice eggs and the louse hatches on the men on the trip over, within 24 to 48 hours, under ordinary circumstances.

We got some lice off the last bunch of prisoners and put them in a bottle and they lived four days at ordinary room temperature. Somebody is wrong about these lice dying so quickly. They don't die so quickly. We have tried this wooden contraption up there, and we used all the paint crack stoppers I ever saw. We used it by the gallon, and we couldn't stop them. We had a fan on the outside and in spite of everything we could do, it wasn't much help. The first design had a window weight on it to stop the leak from that box; we found if we catch it and pull down on it hard, less of the gas would come out; this gas is hard to retain.

We have about come to the conclusion here that there is only one kind of chamber to be used in an enclosed building, and that is some metal chamber. I don't think it will take any more material to make a light metal chamber. You have got to build that door jam absolutely true and plumb. It can't have any variation. If you are going to build it concrete, you have to have a metal door-frame in there, absolutely making that true. Now with our door framed there, they leaked. We put in one rubber gasket, and we put in two and they still leaked.

Now another great trouble we have had with this is the amount of M.B. that stays in the clothes, that are disinfected. That is not going to affect the treatment because they don't stay in there long enough. We have men working in there for hours at a time -- 10, 12, 13, and 14 hours, and we may get some deleterious effect. I think if we are going to get a satisfactory chamber, it must be metal.

I hoped somebody would describe the metal chamber used over at the Quartermaster Depot in Jersey City. Mr. Friend was up here and he said he had one and it was going to be fine. What has become of him? Everybody seems to be working on the problem and nobody gets anywhere. It ought to be put in the hands of somebody so we know what to do. We have been here over a year and have resorted to steam. We have lost that battalion and we have got to do something. We want some help. One section of our delousing plan down on pier 4 is being set aside for different types of metal disinfestation chambers to try and see which one will work.

It is very well to talk about this wooden one and have the disinfestation on the outside. It is alright because if it does lose a little you can put in a little extra; but in a building where you have thousands of people going though -- as many as ***** coming in one convoy, we have got around *******prisoners of war through here so far - under those conditions you can't do that. Another thing, I thought we would heat something about today is this D.T.T. louse powder. I sent 29,000 pounds of the new louse powder over to Algiers from the Surgeon General's Office. Tell me when we can get it? Is that powder as efficient as you think it is or is it an experimental doctrine from the Rockefeller Foundation that worked on it. That looks to me like it would be the answer to everything. It kills lice, bedbugs, cockroaches. If it will do what they say and if it's going to be available in such quantities, all you have to do is spread it around. We have all of our men working on these ships take over the material infested and dust their clothes with the louse powder. It is very effective, but we have a number of cases of personnel becoming lousy after handling the clothes. You can say the lice are going to die. It is hard to find lice except on a man's clothing; a louse stays on the underclothing and in the seams; he gets off and feeds and then gets back on again. He may have 100 lice in his undershirt and his drawers, but he wouldn't have one on his body.

Now there's another thing. We find that there are a great many of these pubic lice. The solution that we use for that is effective. Lice are not dead when they come out of these chambers. After using M.S., they still wiggle around. They will live the next day but they won't feed. As far as a louse dropping off on the floor, there are not very many people going to find a dead louse. If he is not moving, you can't see him. There is no danger in that. They do not die off at once but they do die within a short time. If you know anything more about this lice matter, I would like to know about it.

COLONEL HARDENBERGH:

The D.T.T. is manufactured at the present time by only one manufacturer? And there are other companies coming into the picture who are going to manufacture the various compounds in which D.T.T. will be used. They are just beginning their production at the present time and probably won't be able to put it out in any great amount.

COLONEL MELTON:

Is the powder in existence in sufficient quantities for us to use it on the ship?

COLONEL HARDENBERGH:

I have been told it is. I will find out why you haven't been able to get it. We have had several inquiries that I might answer at this time. The one about the vault and the fumigation -- I feel rather like you do. The engineers can develop a steel vault but not a heavy one. If they could help us out, we would have the answer to our problem. There are two types of installations - one is fixed and the other is fixed. That ought to be simple enough and anyone who has one kind can request the parts for any repairs that may be needed. In my estimation, I don't think plywood is going to last long enough. If the engineers can develop some sort of vault with steel on the side, and a sufficiently permanent seal so that it would work and keep the gas in, that would be fine.

MR. JOHN WOLFE:

We had a proposition to make this chamber with disinfestation chambers when it first came out. Now, the so-called metal chamber was rolled from special material. When you try to produce it, you might call a contractor to make this piece of equipment, but he doesn't put the thing together right so it will hold, therefore the item must be pre-fabricated in the factory like an icebox, and delivered complete. Up to the present time, there is no factory that makes any such apparatus. Therefore, we thought of the concrete chamber. On my last trip to the manufacturing people I hoped there would be a way found whereby those people would prefabricate the doors and set it up.

COLONEL HARDENBERGH: Here's the objection --

MR. WOLFE:

The concrete, I'll admit, was heavy, probably too heavy for piers. Therefore, we have asked the Quartermaster to supply us, wherever possible, with some metal lined boxes for mobile units, to set them up in New York and we'll join them. In other words, install them permanently in mobile units to try them out. If they work satisfactorily, we will design a permanent metal chamber which we hope to get prefabricated. You see the minute you get it inside and heat it, it may open in places and you have to go back and patch it up.

LT BLANTON:

I might add, Colonel Melton, you are going to get the speed of those vaults at Erie Port, and they are also going to be developed by the Lindsey people. These will be compared with each other. I was told by the Quartermaster that that was an improvement over the one that I had severely criticized which I had seen at Camp Lee. I got up to Hagerstown and found the new box being built. If we could get the good features of the two together, we'd have a pretty good box, but there are enough bad features from each place to condemn the box. I don't know who is responsible. I got it somewhere that it costs $800 to have some improvements in there. We could see to it that such improvements are made in writing, and that the manufacturer produces the goods.

COLONEL MELTON:

I should like to make one other remark. In the event we try that in our commercial type and you get excellent results - for in some way they have got to be airtight and gastight - you can put the factory on them. Colonel Lowry is at Hampton Roads. I'd like him to explain.

COLONEL LOWRY:

This plant improved down there in many ways - a synthetic plant. We had the same trouble Colonel Melton had. We managed to obtain from the Navy some submarine net buoys, about 200 cubic feet capacity. We had the welders cut doors in the end of the buoys and mount rubbergasketed doors obtained from the shipyard. We had a whole series of six hooked up on a vacuum. We could pull a vacuum on any one of those tanks in 45 seconds. We have run through two prisoner movements with this equipment so far, and they worked very nicely, with little leaks; I would say in the chambers themselves, no leak; a little bit at times around the applicator, that's all. We have run through rather a long set of experimental work on various arrangements to show what we can kill, and we killed 100% of eggs in 10 minutes or less. Now, we have doubled that time for safety and we worked on a 20 minute schedule. One thing about the vacumm, it enables you to wash gas effectively. We had the same trouble Colonel Melton had, gas escaping in the dressing room. For that, we have sustained suction ducts all across one side of the dressing room and four spans on the far side. We keep that going constantly during the dressing.

We think the plan is working nicely. It is of course entirely dependent on material which happened to be overloaded, but it has worked nicely. If anyone is interested I have pictures. If interested, I will have time tomorrow and I would be glad to show them.

LT COLONEL FARR:

Our time is about up for today. I wonder if there are any questions on the industrial medicine program before we close this meeting. Do you have a clear understanding of everything involved on that?

I have a couple of thins to bring up. I want to remind you again of the questions that we'd like to have given us this evening for further study and particularly those points you wish to raise on the Transport Surgeon Manual, as this is one of the last chances you have to get it.

I'd like to take this opportunity to thank the Surgeon General's Office, particularly the Preventive Medicine Division, for the extremely interesting program they put on this afternoon.

I'd also like to thank the Department of Agriculture and the Chief of Engineers who have contributed a great deal to this discussion.

The matter of keeping infectious diseases out of the country insofar as the Army is concerned is medically the responsibility of the Surgeon General. It is up to us to give every bit of cooperation that we can to aid them in that job. We have covered very many different points today and I hope that the questions we have will be such that we can continue our discussion tomorrow. I believe that tomorrow we will have some representatives from the Public Health who will give a little talk. Doctor Fuller, are you going to be present tomorrow?

DOCTOR FULLER:

I'm sorry I'll not be able to be here tomorrow.

LT COLONEL FARR:

I would like to introduce this evening Doctor Fuller of the War Shipping Administration. I wonder if there is anything you would like to say?

DOCTOR FULLER:

I have nothing to say except to express my appreciation that I have been invited here. I have enjoyed the day very much here, and wish I could have been here yesterday and tomorrow but circumstances over which I have no control won't permit me to be here.

LT COLONEL FARR:

Thank you very much. I hope that you gain from this our feeling of trying to protect all concerned. Occasionally we have to call on the War Shipping Administration to get some help in putting these gadgets the boys were talking about on the ships.

DOCTOR FULLER:

Incidentally, I might say the Public Health is establishing a sanitary code on War Shipping that will apply particularly to the War Shipping Administration, that is boats under charter operated by them. Part of that code calls for the mechanical chlorination of all water. About 6 months ago the engineers engaged on ships were requested by the War Shipping Administration to inspect the plans; that is, the type of plans for different types of ships, not the individual plans for each ship not completed, but plans particularily for proper intaking of water and adjoining, unnecessary cross connecting in the pumping systems of the ship, and so on. Ships are now and will be inspected by sanitary engineers as they come through. The influx of ships in one convoy was so great that it was not possible to inspect all the ships.

The water problem is a little different in merchant ships. It does not carry prisoners aboard as on transports. Many ships on short runs carrying enough water will be able to make the round trip, nevertheless, we feel it is necessary to Chlorinate all of the water in all the tanks - waste water and drinking water.

I hope at any rate that the question of security of water will be pretty well in control in a short time.

LT COLONEL FARR:

Thank you very much, sir. We will reconvene tomorrow morning at nine o'clock.

LT COLONEL FARR:

Dr. Parran has not arrived. I want to take this opportunity to go briefly over part of the organization of the Chief of Transportation, that portion which may be of interest to you. This is more on orientation so that you know who is where. The Chief of Transportation, as you all know, is General Gross. He has two assistant Chiefs: an Assistant Chief of Transportation for Operations, General Wylie, who is now Acting Chief of Transportation, and an Assistant Chief of Supply, Colonel Toolman, whom you haven't met. The Assistant Chief of Transportation for Operations, which is a staff job and not a direct line job is on the staff of the Chief of Transportation. It has functional control over the Operating Divisions which are directly under the Chief of Transportation in command channels or command line. Under the Assistant Chief of Transportation for Operations, we have the Movements Division, Port and Field Agency Division, the Planning Division, and the Intelligence Division which is concerned with Internal Security plus some other G-2 functions. The Planning Division deals entirely with plans for the utilization of transportation facilities based on strategic policies, and are the representatives of the Chief of Transportation on sub-committees of the joint and combined Chiefs of Staff. Port and Field Agency Divisions are actually rear echelons in the Ports for all the nasty jobs that no one else seems to want to do. If you need additional personnel and you can't get it through Personnel Division, the Port and Field Agency Division will try to analyse the job from an operating standpoint to see if the personnel is needed. It also acts to improve methods of operation and to aid along with the Control Division, which sets up here to aid in standardization of port procedures.

I want to emphasize the detailed Movements Division more than the others because that is the one that most of you will deal with. Colonel MacIntyre is Chief of the Movements Division. In it are three main branches. I list my own branch first, of course, the Overseas Troop Branch. The other branches are the International Aid Branch, the Overseas Supply Branch and then there is a Communication and Security Branch which operates the secret teletype net of the Transportation Corps. That Branch is very important and some day will come out with a little bit of "hell" with the Adjutants of the various ports because they got the operation of the teletype stuck down in regular Message Center Channels. The thing was set up for the purpose of being an operational teletype and to take the place of the telephone and still be secret, but that is going to be another argument.

Overseas Troop Branch is the one that most of you will have more of your dealings with. We have the Medical liaison officers from the Surgeon General attached to this Branch because in here is the principal part of Troop Movements in and out. The Branch is made up of a Pacific Section, an Atlantic Section, and an Indian Ocean Section, for outbound movements. The officers operating in those sections are responsible for the areas covered by their sections and to see that the troops get through that area.

We also have the Organizational Equipment Section which is responsible for such headquarters work as has to be done in correlating the movement of equipment with the troops. Our theory is that you cannot separate troops and their equipment if you are going to have them equipped when they get to the other end.

We have the Debarkation Section which takes care of the return of all sick and wounded, the return of all healthy individuals whether they come in organizations or otherwise, and the return of prisoners of war.

All of this takes ships which must be at correct places at the right time. Therefore, we have a Ship Utilization Branch. That Branch is responsible for the scheduling of all troop transports or maintaining schedules on all transports all over the world for a period of six months in advance of the present time. It is used for planning purposes. This branch and the Planning Division are the two planning agencies operating with the combined chiefs and the joint chiefs in an attempt, I should say, to keep abreast of the changes of mind that everybody seems to have, as to where they are going to fight the war and when.

Colonel Stokes is Chief of the Planning Branch. He and I handle between our two organizations, the majority of that advanced planning and also the current planning. We consider planning in three phases: Shorthand Planning, which is immediate planning; Immediate Planning, that planning for the next month; and then our Longhand Planning, that goes out to the end of 1945. We also have a small section, Statistical Section, for working up data on vessels that have gone, utilization of these vessels, to make charts that go into the utilization reports, and all that sort of eyewash. We find this puts in one compact spot the principle elements of the movement of troops both in and out, and their well-being.

There are some of the medical policies that of course have no interest in the actual movement of troops. Although very rarely you do come up with a new disease or come up with some

change in the medical policy, and yet you don't change the picture of troop movements. Colonel Heiskell, who has been here in the Field Division, is the other individual officer in the office of the Chief of Transportation who is particularly concerned with medical problems. Our liaison officer works with him on those problems. I am giving you that more as a sideview than anything else. I think it may be of help to you. Most of you know who the officers are that operate many of these divisions. In the Army, you are supposed to be interested only in the organization and not the personality, although, peculiarly, most troop movements depend on personality. So unless you would like to raise some questions, we will pass this one for what it is worth.

We are now entering our closing session of the conference, one that I found to be particularly interesting. It was very clear to me what we were talking about until yesterday afternoon when Colonel Hardenbergh kind of floored me, but it was still interesting as far as I am concerned. I have learned a great deal from the presentations. However, presentations at the conference are principally setting up the means for further discussion and in these discussions we can raise many questions that have been bothering us and the operation of our ports. We do have another subject or the continuation, shall we say, of one of our principle subjects to be discussed before we enter into the free for all of question and answer.

We are very fortunate in having Dr. Oleson a Medical Director of the United States Public Health Service, Chief Quarantine Officer, Port of New York with us this morning to discuss the prevention of communicable diseases in the United States by coordination of agencies involved. As the Public Health Service is charged by law with this function I am sure that Dr. Olesen will give us an extremely interesting discussion.

DR. OLESEN:

Mr. Chairman and gentlemen: Within the past few weeks there has been considerable space devoted in the newspapers to a discussion of the topic which somewhat interests us. The sub-committee and mobilization of the Senate Committee on Military Affairs pointed out the fact that in the Port of New York there is a lack of centralization and pooling of resources so that things were not going well. There has been some editorial comment upholding the fact-finding of this subcommittee and it occurs to me that it touches us rather closely because of the sanitary resources of the Port of New York which are somewhat scattered and not coordinated to the extent that the best results could be achieved. We have a precedent for establishing a coordinating committe in the security efforts that have been put forth in New York, and I well remember some conversation that occurred between General Phillipson, who I believe was the Corps Commander at the time, and some one who posed a question to him.

It was somewhat on this order. We were looking, incidentally, rather roughly at a pile of reports on the desk of the Collector of Customs at the time this meeting was held. There were sixty-eight fires on docks in the metropolitan area of New York. We were non-plussed as to what could be done about this particular aggrevating occurrence. So someone asked General Phillipson, "Is it possible for the Army to stop this sort of thing? Could you so pose your forces that this sort of thing will not occur?" General Phillipson with a little twinkle in his eye said, "Yes, we could do it but," he said, "no ships would sail in the Port of New York. Everything would be completely stopped".

And I think that that should be recalled in connection with what I have to propose too and what I may have to say on the subject. It is simply this: Yes, we can prevent disease from entering the Port of New York; and yes, we can prevent disease from entering any of the Ports in which you are stationed, but there would be no commerce so that we must take chances. We must liberalize our procedure. We must take such measures as will be within reason. I thought that that was a very interesting point that the General raised at that time and I thought that that might well serve for the theme of what we may discuss today.

We can stop it, yes. But there will be no goods brought in or out. Everything will simply be stopped in the Port of New York. In the Port of New York we have a number of agencies devoting their attention in one way or another to the subject of sanitation. We have some of course that are devoting their attention to medical care. I am not going to discuss the subject of medical care because that is entirely separate, but I shall propose today the desirability at least of setting up a small organization, possibly a very flexible one. It need not be a rigid formal organization or grouping, but it is possible in some of the larger ports. It would be advisable to have a well-equipped public health officer, an officer with a public health view-point. Not a dictator, but someone to do the lay work of telephoning to accumulate the material that is needed for making a success of a small organization devoted to sanitation.

Within the last week we have had such a conference here in New York and it has been most helpful. Possibly if we had the organization presided over by not a dictator, but a person who could have regulated the affairs of this group, it might not have been necessary to have had this particular meeting. The meeting was held for the purpose of ironing out some of the perplexing problems that occasionally arise here. Heretofore, we have always gone to each other in the kindly, friendly spirit and have resolved our difficulties by private conversation.

I just want to review for a moment, if you will, the organizations which enter into this picture, and I refer briefly to the principle activities which they perform, leaving the public health service until last. Possibly not because it is least, but simply because of convenience and probably a little longer discussion for the purpose of setting forth in rather clear terms the functions that are described to the public health service, its jurisdiction, the things it can do, the things it can't do, and the things it is not equipped to do. No one is more conscious of the difficulties under which we have been laboring than I have been because we have been requested to perform certain functions that we simply were not prepared to undertake.

I might first mention the Army Air Forces because it has a very large share in this activity of safeguarding the health of the poor by efforts of sanitation, in preventing the influx of communicable diseases from the outside; and I wish to pay a very small tribute, but well deserved, to Colonel Melton, the Port Surgeon at New York, to his assistant, Major Schuhmann, and also to Major Buzzard on his staff. All these gentlemen, I think, have maintained their equipment under very trying circumstances. They have done this at times, I am sure, they would have been willing to throw a brick through a plate-glass window. They have always been kind and considerate and we have reached conclusions that have been helpful. You all know pretty well what the Port Surgeon does from your experience in other communities. I am not going to dwell on that very much except to say that they are bearing a very large and important share of the responsibility of getting these diseases stopped at the gate.

In other words, we would like very much to pool the sanitary facilities of this Port. I think that the sanitary facilities of other ports should also be pooled. It is a good "catch" expression - - "pooling the port". That is a subject I am particularly devoting myself to this morning. The Navy also has a very strong interest in this, but not to the extent that the Army has, for the reason that the Army has set up its own delousing facilities. It also has its facilities for disinfestation and fumigation. There has been excellent coordination and cooperation with Colonel Hayden, who is the Advisor to the Commandant of the Third Naval District. There have been inspectors who made the inspections on these vessels and then reported to us, but they haven't been very good, because they have been lay inspectors who have no idea of what was needed in the way of sanitary

inspection and have thrown into our laps many problems that probably never should have arisen and should never have been referred to us.

The W.S.A. has a very large share in this by reason of the large number of vessels which have come under their jurisdiction, for the purpose of transporting supplies and troops. Many times these W.S.A. vessels are not equipped to carry troops. It has been a sort of great annoyance to all of those in contact with vessels that they have not had adequate sanitary facilities; that they have not had adequate sleeping facilities, as the regular Army transports and Navy transports have had. There is a problem to be settled there as to who is responsible for sending out vessels that are not equipped to handle prisoners of war. That should be considered.

I am just scurrying over this lightly. You will recognize in your own communities the counterparts of the organizations I have mentioned. I want to mention to you some of the organizations that we come in contact with here in New York City, particularly some rather odd and rare groups. We have public health services of some of the allied nations. For instance, the Norwegians have their own Public Health Service here in New York. They have a competent man at its head, and another man to supervise affairs in Washington. The British have the British Ministry of War Transport. Those people are immensely cooperative in anything you ask them to do.

We have had some problems with venereal cases -- venereal diseases which have come into the port on Norwegian and British ships, and owing to the rapidity of movements, owing to the necessity for them to depart as quickly as possible, these venereal cases are carried on them without any treatment. We have had some correspondence with Directors of Public Health Services of foreign nations and they are very responsible. The longer I stay in the Public Health Service the longer I believe much can be accomplished by consultation and persuasion, rather than by opening a book. We have settled many prime problems by going to the people themselves who are involved and reasoning with them in a friendly way. I believe there is a feeling in New York probably that many of the things that come up can be settled that way. As far as I am concerned, they always can, and certainly we can always reach a point of departure where it is favorable to both groups and where there will be no quarrel.

One of the initial organizations in New York is the little organization known as the Medical Directors and Steamship Companies under Commander Terwilliger, representing the Grace Line formerly, and I believe he is still a member of the organization. Dr. Gatler, of the United Fruit, has for years

done all of his own fumigating with hydro-cyanic acid with as great an efficiency as we have ever undertaken. Dr. Hewitt, of Standard Oil, has also been very helpful. You will find men of that type always ready for consultation at such conferences as may be desired affecting their vessels.

One of the groups that should probably be considered is the Pest Control Group. By reason of the lack of Federal facilities for fumigation and disinfestation, we have to rely very heavily upon this group. We know the secretary of the association very well - he lives over here in Brooklyn. Mr. Butner is a fine speaker, and I think a very honest gentleman, but he can't be honest for the whole crowd he represents and, I feel at times we are being "gyped", to use the colloquial expression, by reason of making contracts with these people on a cost-plus basis. I think we are paying too much. I am sure if we could have the facilities at our disposal for taking over this work, we could save a great deal of money. They are short-handed too by reason of induction and other drains on personnel, so that they are not in the same position anymore for undertaking large jobs that they formerly were in.

Those are some of the groups I should like to mention particularly as being members of a little flexible organization such as we might easily set up. In the large communities, possibly, it would be wise to have a competent public health official with an officer with a public health view-point to do the leg work and make the suggestions. I would like to suggest particularly in a little conference group of this kind, it would be desirable to have a little mimeographed statement of what each organization included therein, does for sanitation in the port. There should be telephone numbers of the Chiefs of the units involved. It would not be an expensive thing. I have seen this done in other communities. My particular reason for advocating such an organization is that it has always worked well in public health organizations. I came in contact with the Public Health Federation in Cincinnati many years ago and found they had two representatives from every organization in the City of Cincinnati, who were in any way interested in public health. That is one of the most powerful organizations there. It has a dynamic secretary and it is one of the most dynamic organizations in the City of Cincinnati because it has political power as well as persuasive power. They have achieved and simplified this cohesion.

I think we are too loosely knit together at the present time to achieve the best possible results. Then, coming to a brief discussion of what the Public Health Service duties are in this community. We have taken stock recently because of the various problems that have arisen and we find we are not as well equipped

to undertake work as we should like to be. We were caught rather flat-footed by the unexpected and sudden demand made upon our resources, and by reason of losses of personnel due to induction and resignations by poorly paid men who went into ship yards, which is a chronic state with every organization. I am not bemoaning the fact. I know it occurs with every other organization. Just now we are much better off than we were for a long time by reason of the acquisition of 25 enlisted men at this port, and those of you at other ports know, too, that the Coast Guard has also loaned or detailed enlisted men for duty with quarantine stations. We are fortunate in having 25 very good enlisted men who were detailed to us and help us in our disinfestation and inspections, and some of them are showing marked versatility in their field, so that we can rely upon them. Before long we expect to expand greatly.

The Coast Guard derives its surgeons and physicians from the Public Health Service. So that when a submarine is sighted and the "same is sunk" it usually means there is a Public Health Service officer on board to do the work. We have at our station at the present time, a young man who just came off the **********, the Coast Guard ship which sighted a sub and did away with it. Some of his accomplishments worked so well I should like to boast about them a wee bit, because he had some serious injuries due to shell fire from the sub **********. He had one nice case which I should like to mention briefly -- it was a hemorrhage of the liver, which he stopped by transplanting a piece of muscle and knitting it in so that the hemorrhage was somewhat subdued. He is a very young fellow and I think he did an excellent job. I just mentioned this to impress upon you the Coast Guard attention from the Public Health Service and I think they're doing a first class job.

The Coast Guard, of course, has a very strong interest in pest extermination. Heretofore, we refused to do anything for them on the grounds that cockroaches and water bugs and lice, and other things, were a nuisance rather than a public health menace. We have in the past consistently found fumigation for the extermination of rats, that being one of our chief functions which we have studied for many years. It was 20 years before we encountered a single case of bubonic plague. It was last January 1943, when a French vessel came from Casablanca with rats and fleas on board, which were undoubtedly infective. Due to some very poor laboratory work, not in our own station, confirmation was entirely sour, which is the quickest and best way to express our feelings upon this particular case, but there wasn't any question about the authenticity of the diagnosis as far as we were concerned. Every victim was killed and we feel that 20 years of constant endeavor which we

were just about to give up, has repaid us for that long experience. We are now going at it with redoubled energy. The Public Health Service has some things it can do with those 25 Coastguardsmen. We are now able to disinfect and to fumigate small craft of the Coast Guard, which are vermin infested. We never did that before, but we feel now that in return for the help given us, we should make some adequate return to the Coast Guard for this work.

Admiral Clark has cooperated admirably in this work. He simply said that if any of the men did not come up to expectations we will supplant them. Colonel Melton has sent several of his men to us for training in the inspection work, which they like to know about too -- and I think they know the job pretty well as it is already, but they thought we might exchange some ideas on the subject. We are constantly getting men from other parts of the world who come in here for training or to see what we are doing. We are training men from Bermuda and Haiti, and if we can use influence just a little bit, we will make for more uniformity of procedure and do a better job. Our principal work then is to fumigate cargo vessels -- not the vessels belonging to the services, although we are planning to undertake that on behalf of the Army and Navy. We feel that is not the mission we have to our fellow services. We can at the present time do a reasonably good job. Fumigation of the "Bermuda", one of the two crafts which ran regularly between New York and Bermuda, before the War. I think the **********. The ******* is still afloat. It is a **** stacker with one painted a different color. That is a big job and when a ship like that came in, it meant we had to, in the past, divert our entire personnel, which is relatively small anyway, to this single task of fumigating a large vessel. Now without augmented personnel, our augmented group of workers, we are able to undertake some fairly decent sized jobs and we are very proud of that fact.

The Public Health Service still hasn't any arbitrary authority to do this, that, or the other thing. We can't hold vessels in quarantine unless it has an actual or expectant case of quarantinable disease and, unfortunately, quarantinable diseases are those we seldom see. You are all familiar with quaqntinable diseases, cholera, plague, smallpox, yellow fever, typhus fever, anthraz and psittacosis. Those are the ones we seldom ever see. They are certainly not very large. Personally, I think I would rather encounter a case of ---- I would be much more afraid of a case of poliomyelitis, or meningitus on a ship. I should mention the fact that the Department of Health of the City of New York, has an active picture of the problem and they have been very helpful. They take care of minor diseases, such as measles, mumps, chicken pox, scarlet fever, poliomyelitis. Poliomyelitis is certainly not in my estimation a minor disease. How it is communicated

and how it is conveyed I would like very much to know, and how to stop it would interest me still more.

But the Department of Health takes these cases on after they pass us a quarantine. We let them know what we have. But that is the only absolute jurisdiction that we have at the present time, and I hope in the prospective that changes that may occur and I should like to be around to participate in making any changes, because I think quarantine as it stands is inaccurate and is a hit and miss affair which should be radically changed. We have under consideration with the Surgeon General's approval, at the present time - his tentative approval - because the plans are not definitely laid out, to let certain vessels pass quarantining without inspection. That would be an innovation which would be much appreciated by the shipping interest and especially the tanker people involved. The rapidity with which tankers must be in and out of the port is startling. The personnel there will tell you that they don't get ashore for months at a time. They get alongside a dock, load their oil, discharge it, and don't have a chance to get off the shipat all before they are on their way again. We would like very much to let tankers and let certain cargo vessels from certain key ports in the world, go in and out of the New York Port without stopping them for quarantine.

Quarantine is an outmoded word. I wish that we could find a better word for it. We in New York rely on the expression "ship sanitation". We think that if you have a clean ship, half your problem is solved. If we can clean ships here adequately before they go abroad, we think we have done a good piece of work. If we can get them free fromrats, for instance, it will be a real achievement, and that has been our aim for a great many years.

One of the interesting things that came up some 15 to 20 years ago was the fact that when we fumigated a ship we seldom recovered any rats. There wasn't anything on there as a result of the fumigation. On taking stock we found fumigated vessels that didn't have rats on them and that was the reason we didn't recover them. Some bright mind on the quarantine thought of the very pleasant task of going out on the ship and making an inspection to see just what there was on the vessel. And at the present time, as Lt. Grayson, of Col Melton's staff will tell you, we have inspectors who make an inspection on the ship and they come home and say they have three rats or fifteen rats, or twenty rats whatever the estimate may be and as a result of trapping and fumigation we are able to check upon our estimates as to the extent of knowing how far off we are. It is rather amazing to see.

As a result of trapping and fumigation we are able to check upon the results and derive estimates on the number of rats destroyed. It is amazing how closely these men with their long experience and training are able to estimate the number of rats on a ship, so I think that is a fair summary on what the Public Health Service is able to do at the present time.

We have no authority to stop the ship and hoist a yellow flag on it because we think there is something on board. We have to know and be definit about it. We do have authority to suggest, pursuade and consult with the people concerned that it would be a good thing to do so and so. In that way we exert a little pressure on them. With respect to the Grace Line ships we would go around and try to sell the idea that such and such a thing would be helpful. This was done by way of suggestion and, of course, we would be very well pleased in having cooperation and hving them agree. If there were objection O.K., but if they agreed we were pleased with the cooperation. I'd rather deal with the person who is not so complacent in whatever we have to offer rather than with one who accepts every suggestion set before him

We always had the problem of continuous outbreaks of diarrhea on the Old Rotterdam which never left a Port without having unusual cases of diarrhea on board. We tried just as hard as we could on the Swedish vessel, Kungsholm, which was a very clean vessel, to prevent the outbreak of diarrhea; and although it was a very clean ship it always had these outbreaks. We participated in inspections and always made suggestions, but outbreaks of diarrhea still occurred and people would be afflicted even for several days after they had left the ship. Our efforts on the Kungsholm were utterly ineffective in attempting to stamp out this particular infection. It was a very annoying thing, because the company was losing a great deal of money. People just simply knew that they would get diarrhea on that boat and that they would suffer for a day or so after leaving it. We tried everything without any results, even down to the examination of the food, the food handlers, the galleys, and the kitchen utensils. It was just one of those things and our suggestion didn't seem to eliminate outbreaks.

In the case of the Grace Line Ships, we consulted with Doctor Terwilleger, and we would go through the ships very carefully. He agreed that there was something to correct and he did correct them. And that is the best result. It is all right to make a promise but the real changes are brought about through cooperative efforts and they are the most pleasing because they help out.

I wish to lay special emphasis on the fact of having a clean ship taking on clean people at the Port of Embarkation. That boat has a better chance of escaping all of those maladies that beset a ship, than just dumping them on any ship at a foreign port, that happens to come along. I have been very much impressed with this for a very long time, ever since my childhood days, and especially since I was in the Philippines. No army transport ever left Manila without first going through the process of steaming all of the effects of the personnel on board.

Incidentally, when I was in Illo-Illo I had dinner with Colonel Brechemin one evening and in addition to a wonderful dinner that was placed before us, upon the ceiling there was painted a complete table with all the beautiful food that the Spaniards can provide; so if you weren't satisfied with what was placed before you, you could always look at the ceiling and get something different there.

Now at Marivalous, we had a quarantine station where the ships were processed for cleanliness. The Marivalous station is at that point, as you know, on Bataan where all of the dreadful fighting occured before General Wainright and his men suffered heavy losses and before they could get back over to Corrigedor. I have been very much upset by the thought which has been in my mind for a long time that the Japs are now occupying my quarters in Marivalous. The transports used to stop there very often where they were taken over and the men were bathed and their clothing and effects steamed in the steam chambers, and the ship was washed down, and a disinfectant used, which I don't approve of at all at the present time. I think that is getting back to the dark ages. A good old scrubbing and washing with soap and water always seems to be more effective.

Within the past few days we have had some discussion as to what should be done after a mechanical cleansing of these boats which bring back prisoners-of-war. The suggestion was made that we use a one or two percent solution of cresole, or creoline or lysol or something of that kind, and I rejected the suggestion which I hope will meet the approval of the participating agencies. I don't think that they do any particular good by just substituting one odor for another. It gives a feeling to some folks of freshness and cleanliness but as far as the actual worth of it is concerned I think we can rely on the good old scrubbing soap and water and a little soda if you want to use it. Mechanical cleansing means just that and it does not include a return to the old days. I am not going to go back to those dark ages again but you will be surprised if you took a cruise around the country at how many Departments of Health, including the one in Washington, D.C., were still relying upon disinfectants for the prevention of communicable diseases.

In concluding these desultory remarks which I hope will be the object of some discussion and some criticism if you care to indulge in it. My hide is fairly thick from long experience in the quarantine service and I am used to being kicked around. In fact all of the delays which occur in the Port of New York are always due to quarantine and that is reason enough for being subjected to much criticism for any delay regardless of whether there is illness aboard, whether, the quarantine doctor is delayed, whether, there is a lack of diesel oil in the Coast Guard cutter or whether it is due to a faulty cylinder or some other defect, or somebody falls down and breaks a leg. No matter what the cause for the delay its due to quarantine. In Manila all the newspaper stories usually started with the phrase; "After the customary quarantine delay", no matter what. Of course that is a fair criticism because we have not always been prompt to revise our procedures and there is a need at the present time for all of us to re-examine all of our procedures in the light of recent events and developments to see whether or not we can shorten and curtail and eliminate worthless procedures that we have been engaging in.

As far as I am concerned, I am willing to take the word of the master of the vessel as to the health of his crew, upon entering the Port of New York. Now that is a daring statement to make, but long experience has taught me that you can rely pretty well on the statement of a lay person, if you will place that responsibility upon him and let him hold the bag. Most of the men who operate vessels are very jealous of their certificates. They would go so far as to cut off a right leg or lose a arm rather than lose their certificate of ability to navigate and command a vessel. I find in my own experience by asking a master or the first mate or the chief steward whether he has veneral disease on board, he will be very prompt and thorough in telling you just what he has because the men on board usually come to these fellows for treatment. As far as I am concerned it would not be a difficult thing to take their word for it, as regards health conditions. As long as a man is able to stand up and muster I believe, he has a good chance of living, for then he will fall into the hands of his medical men of the company and they will take good care of him, or the case will be reported to the Coast Guard who will send out a cutter to remove him to a hospital.

To recapitulte briefly, I would like to suggest a desirability of having an elastic organization in the Port, one that is not necessarily too rigid, that may be used for such a venture so that we may gather together and know who they are, what each is preparing to do, and if possible, in some of the larger Ports, to have a responsible officer who can coordinate these different

agencies just as this Port Security Agency has built up quite a little organization in New York. They have placed under Mr. Flynn experienced customs officers who frequently call me up.

I want to mention, I am constantly in receipt of telephone calls from physicians, from laymen, who want to known why it is that some vessels no longer have rat guards on their lines. Such individuals living in a beautiful apartment house on the river shore look out of the window and see no rat guards on the lines and call up and ask why this neglect is permitted to go along. Our reply is a very simple one, and I believe, a legitimate one. It is that we prefer to spread our small force of inspectors and others on the more essential features of ship sanitation and not to expend the time of hundred of inspectors cruising around the docks to see whether there are rat guards on the lines. We inspect these vessels very carefully when they come in. We know their rat condition and we do not feel that rat guards are essential although they are often effective. We have actual photographs of rats climbing right over these rat guards and we don't feel that will take the place of a competent and thorough inspection and fumigation when it is needed.

COLONEL FARR:

Thank you very much. Gentlemen, do you have any questions that you would like answered? (No questions)

DOCTOR OLESON:

Probably many of you just have some things you would like to bring up. I suspect there are. I don't think you are very content at all with what I have said.

COLONEL MELTON:

I would like to take this occasion to thank Doctor Oleson for his remarks and thank him for the hearty cooperation we have had with the Public Health Service. There is one thing I would like to recommend to all of the Port Surgeons and that is the assignment of a certain number of bright young men to your Public Health Service to get training in ship inspections. We found it very beneficial. He has been kind enough to train a number of these young men and we find that they can do an excellent job of inspection of ships. Furthermore it relieves the officer personnel as we do not have enough officer personnel to do that. Is it in order, Doctor Oleson, would it be all right for you to outline something in the nature of a plan to clean up these prisoner-of-war ships?

DOCTOR OLESEN:

I would depend upon Colonel Farr because he has a schedule.

COLONEL MELTON:

Perhaps you can mention it briefly for the benefit of the others.

DOCTOR OLESEN:

I think the thing may be summed up briefly by saying that at the present time we believe that prisoners-of-war should be deloused under the direction of the Army for the reason that the Public Health Service has no facilities in this Port although it may have in other ones. Feeling that ship sanitation was one of the rising features of future quarantine, and feeling that ship masters, agents, operators, and owners were getting the idea that a clean ship was highly desirable, we gave away Hoffman Island which you could see from here. It is a beautiful Island down the bay about 5 miles and is now occupied by the Maritime Training School. It is well worth seeing those schools. They are running a first class job down there for the training of Merchant Seaman and have excellent officers there for the needs of the occasion. The steam infestation plants had been dismantled and thrown to the scrape pile. We simply lost everything we had when we gave it away to the City of New York, and it was later taken over by the Coast Guard, and then by the Maritime Training School. We have no facilities for the School at all and no facilities for delousing. Naturally, it falls to the Army which was foresighted enough, I would say, in the development of delousing facilities. I think they have done an admirable job. They are doing a first class job at this Port and they are doing it at the other Ports too. We conceded that it should be done for the Army and Navy and I have had some conversations with Colonel Melton about it, that if a vessel came in with a case of epidemic typhus, it would be processed for us too. Of course there is difficulty in this Port because of the several jurisdictions that exist over vessels carrying prisoners-of-war. The army has its own transports and takes care of them throughout. It is the old story of putting clean people on clean ships, and we wouldn't want to put troops on a dirty ship. That is the sole purpose for which Colonel Melton has been striving to get cleanliness, which can be achieved by an orderly program including the mechanical cleansing of vessels with a good thorough job of scrubbing up, which I think will take care of most of the

things that are needed. If there is infestation I believe there should be fumigation with a lethal gas for those occasions when it can be demonstrated that it is needed. It is only through inspection by trained people that you can determine whether this infestation exists, and that has been the reason that we have been so ready to help the Army in training the man that they have sent to us, who, I think, are pretty well equipped to make inspections of vessels and to make suggestions and recommendations.

The War Shipping Administration is getting its vessels from private operators and owners, which raises a serious problem because they are chartered and they are paid for navigating the vessels in and out of the Port as quickly as possible. With additional inspectors this will enable a quick turnaround of the vessel. We have no way of knowing about the arrival of vessels unless the Army and the Navy inform us. We have to devise a simple form for reporting the arrival of a vessel in port.

There is, however, provision in the Quarantine Laws and Regulations for recognizing our friends in the Army, Navy and Coast Guard by filing a certificate. It will prevent and obviate the necessity of dropping anchor and waiting for our Doctors to come aboard. And we are fairly busy at the present time I assure you. When convoys come in with fifty, seventy, or ninety ships at a time you can readily understand that an inspection of vessels in those numbers poses a considerable problem for us. We have been able to do fairly well, although we are still the object of some criticism for slowness. The fact that we have ten doctors does not mean much to a man who wants to get his ship in and out quickly. We are doing that fairly well at the present time and satisfying most people. To obviate the necessity of stopping a ship for quarantine in this Port or in other ports I hope this certificate may be filed by the medical officer with the quarantine station notifying us that his vessel is in. Then we can make our plans for inspecting the ship if we are asked to do so. We can only inspect on request. We cannot barge in and take over. We do not want to do that. We prefer to be asked for advice, or for consultation, or for an inspection, and then it would be necessary for us to adjust our schedule so that it can be done. After a mechanical cleansing without the use of a disinfectant, we will have to have a final statement that the work has been done, and we would like to accept the statement of whoever does the work, even down to the commercial fumigators whom we know very well as to the type of job they turn out. We all know them pretty well. The commercial fumigators, I am sorry to say, are not strictly reliable but we know most of them and know just what they can do. We prefer to do it that way because we think that will cause the least delay to the ships.

COLONEL FARR:

Colonel Lundeberg.

LT COLONEL LUNDEBERG:

The Public Health Service of course is charged with the responsibility of protecting the Public Health of this country from the introduction of dangerous diseases. I think that went along beautifully in peace time. The channels of communication were set up and we know when ships left and when they arrived. All were agreed as to what the procedure would be.

There may be others here who do not have the picture clearly in mind of the relationship between the Port Surgeon's Office and the Port Quarantine Officer. How is it possible for instance for Dr. Olesen to know when a certain ship is coming in from a contaminated port? Or is he interested in that?

DOCTOR OLESEN:

We are very interested in that Colonel, but somebody will have to tell us because we have no advanced notice. Our radio is out of commission and our reports are very meager at the present time. Unless we are told when the vessel arrives and where it comes from, we have no way of knowing. Therefore, that will be a cooperative feature that should be arranged between a Port Surgeon and the Quarantine Officer so that a definite plan may be laid down whereby we may be advised and make arrangements accordingly. Remember of course that your real interest is only in the communicable diseases and not in the diseases that you are going to be interested in when your troops come back.

LT COLONEL LUNDEBERG:

Lets assume, Casablanca or one of the Algerian Ports is an infected port in a real sense.

DR. OLESEN: It is now.

LT COLONEL LUNDEBERG:

I'd like to ask Colonel Melton particularly; how do you work it out, how do you get around it, or how do you adjust the rules of inspections in this situation? You, of course, know when a ship comes from and infected port. Does that ship bring along with it a bill of health? Are you notified what the situation is, or is the Public Health Service?

DOCTOR OLESEN:

I'd like to say, Colonel Melton may be helped by saying that the American Consul has been relieved in Casablanca and the American Bills of Health are being prepared by the Army, and that each vessel from there does or should in so far as military secrecy can be conserved, carry such a bill of health when it comes in. This gives a fair picture, not too accurate, of the quarantine diseases prevailing Casablanca at the time the bill of health was obtained, and also the other diseases. If Colonel Melton wants to know just what the condition was at Casablanca the time the transport left, he can find out from the Bill of Health.

I think that its a shifty business of evicence; I prefer that we lay very little emphasis on some of the bills of health brought in for the reason that they don't give a very clear picture as it exists. We prefer to rely upon our inspections as to the presence of rats, trapping, of fumigation, and taking them into our laboratory and innoculating a procedure which we keep up faithfully at all times. However we never have gone on transports unless by request. We feel it is out of our jurisdiction and anyway we haven't sufficient force.

LT COLONEL LUNDEBERG:

As I understand it, the Public Health Service does not inspect every inbound ship.

DOCTOR OLESEN:

Correct.

LT COLONEL SCHUHMANN:

Colonel Lundeberg, I'd like to say that we worked out with Doctor Olesen a form of certificate. We worked out a certificate on his suggestion - I mean he has helped us write this certificate so that it would give him sufficient information. It is addressed to The Chief of Quarantine Office, United States Quarantine Station, Rosebank, Staten Island, N.Y. That's in our permanent instructions.

COL. SCHUHMANN:

I am reading from our instructions to Transport Surgeons. It states:

"THIS IS TO CERTIFY THAT:

1. The sanitary conditions of the vessel is satisfactory and there has been no quarantinable or other communicable diseases during the present voyage."

It goes on down here - I won't name the quarantinable diseases, Dr. Olesen already mentioned them. It states:

"3. The vessel has not visited Foreign Ports known or suspected of being infested with Cholera, Plague, Epidemic Typhus Fever, Smallpox, or Yellow Fever".

That's one paragraph that you may refer to, or you may use the next paragraph labeled "OR 3.":

"OR 3. The vessel has visited Foreign Ports known or suspected of being infected with Cholera, Plague, Epidemic Typhus Fever, Smallpox or Yellow Fever, but has held no communication which was liable to convey infection."

Or still another:

"CR 3. Communicable disease other than quarantinable has occurred during the present voyage but is under control. Active cases have been reported to the local civil health authorities upon arrival in Port.

4. The vessel is believed to be free of rats and is not in need of an infestation inspection or fumigation by the U S Public Health Service.

"OR 4. Evidence of rat infestation has been noted and as inspection by the U S Public Health Service is requested with a view to instituting corrective measures.

5. Duplicate copies of United States Bills of Health are forwarded herewith.

"OR 5. Unites States Bills of Health are not available."

Now in the distribution of this, the original is given to the master and two copies are presented to the Port Surgeon, one of which is to be forwarded to the quarantine officer. Apparently Dr. Olesen has not been receiving them.

DR. OLESEN:

The Colonel has not been getting them.

LT COL SCHUHMANN:

Col. Melton has a note here from which it appears it is desired that our office, rather than the Transport Surgeon, notify the quarantine station when a ship has arrived. We should also state whether or not an inspection is necessary and the ports from which it departed.

DR OLESEN:

I might say that this certificate, which was devised locally, has no official approval. It was designed for the sole purpose of expediting ships. We feel in every fibre of our beings that is our function here above everything, we'd say, at any time, in addition to making things safe as possible, to get these ships in and out as quickly as possible, I believe we have achieved it. We caused very little delay to the Army Transports and to Navy vessels. It is a new thing and I have no criticism to offer at all. It is so new we'll have to wait for the results.

COL MELTON:

We'll see that you get this.

LT COL FARR:

I think it will be very helpful.

DR OLESEN:

Then we can offer to give you the benefit of our inspections, occasionally, if you desire them. We never want to force ourselves upon you unless something goes radically wrong and it seems necessary to step in. I don't think that will ever occur. We will always be able to work amicably together, if we just understand what is expected of each other, and I am sure that is the solution.

LT COL FARR:

Regarding this matter of notification prior to arrival, I am not just sure how that is handled in the Ports, and I am not just sure of how much notice you want; whether you want notice before they arrive or not until they do arrive.

DR OLESEN:

Until they do arrive, we can't have that over the air. That is prohibitive. We get from the Port an account of cargo vessels coming in but not of the Armed Forces. I don't think it would be of particular advantage to have that in advance. It would be ample to get it when it gets to port. By that I mean we can go to the ship Surgeon and the person who renders the certificate on an armed vessel

must be - I don't say a commissioned officer - but certainly an officer of the Army, Navy, or Public Health Service. It isn't available to Pharmacist Mates assigned, or a vessel without any documentary forms aboard.

LT COLONEL FARR:

Then the thing that is necessary to you is that a certificate be promptly moved from these vessels to your quarantine stations.

DR OLESEN:

I think that would be helpful. I don't know as to how necessary it is. I shouldn't say it was absolutely necessary but it would be helpful not only to us but to the personnel of the Army and Navy.

LT COLONEL FARR:

I assure you that our Port Surgeon will cooperate on that. I am not familiar with other Ports. What is your San Francisco set-up on that?

BRIG GENERAL DE WITT:

The set-up is not the same in San Francisco. Our relationship with the Public Health Service is very cordial and very cooperative, but they have not been able to give as much assistance to us probably because they do not have sufficient officers there as Public Health Service Officers on our ships. Every ship coming in our harbor having such a certificate as Dr. Olesen spoke of was transmitted to Dr. White, the Quarantine Officer there. He decided which ships should be fumigated; but that is the only relationship we have had up to the present time.

DR OLESEN:

That was the reason for my suggesting the desirability of having this small group.

BRIG GENERAL DE WITT:

I think that is extremely important Doctor. When I get back, I may contact Dr. White - I can't think of the other, Dr. Harrison and Dr. Gallagher, the health officers of the City, and the other agencies and get them to form just such a committee.

LT COLONEL FARR:

Do we have any other questions?

COLONEL BRADISH:

At the Port of New Orleans some of these problems were discussed at a conference with Dr. Walsh of your Service, the City health officials and the State officials. They had a variety of problems. They had the proposition of handling quarantinable diseases, receiving and transmitting communicable disease cases occurring amongst civilian passengers. Of course, we had the responsibility too of handling the military classifications. It was agreed that there would be no quarantine inspection of Transports or any vessel upon which we had a commissioned medical officer. All cargo vessels are stopped at quarantine and are checked by Dr. Walsh of the Public Health Quarantine Staff. However, he received no advance notice of these vessels; they simply come in quarantine. For purposes of security we didn't want to be transmitting papers around, showing the arrival of Troop Transports and so on. It was simply agreed that there would be transmitted to Dr. Walsh a simple statement that the Transport had arrived and had satisfactory health conditions prevailing on that vessel. The Bill of Health certificate does not go out of port for quite a while but is available for his information any time he desires to see it. He further agreed that if a case of quarantinable disease did appear in Port we could call him into conference immediately in order that he could carry out the proper responsibilities on that type of case. It would work very simply and very satisfactorily, and I think that he feels that he knows what is going on. We feel that we adequately and satisfactorily cover the security requirements on a vessel and that we have not transmitted information into channels that perhaps don't take the same security measures we do on the information we get concerning the vessel.

LT COLONEL FARR:

I think that is a very desirable set-up. I suggest if you transmit the name of the vessel then you can submit everything; you might as well add everything.

COLONEL BRADISH:

The name of the vessel is not transmitted.

LT COLONEL FARR:

Transmitted by form number?

COLONEL BRADISH:

Simply a statement that a vessel has arrived. As a matter of fact no kind of statement.

BRIG GENERAL DE WITT:

I'd like to supplement my remarks by saying in connection with arrival from infected ports, also Hawaii, that they are required to raise the Quarantine Flag coming in from those ports, and it is required that Quarantine Officers be aboard every one of those ships, in spite of our certificate.

DOCTOR OLESEN:

I wouldn't want to delay things that long in New York; I'd be afraid.

COLONEL LOWRY:

In Hampton Roads we have been able to work out a three weeks credit between the Navy, Army, and Quarantine Service. Our own officers have found it works out very well. The Navy, of course, gives us information on handling arrivals as soon as possible. We assume the responsibility for keeping the Quarantine Officer informed of the work pending.

We have also worked out a method there of handling the ships which we do not want to stop in Quarantine. Certain officers of the Navy are qualified to issue practique and certain officers in my office are qualified to issue practique, although we can call in the Quarantine Officer for assistance at all times. The Quarantine Officer has a good mechanical arrangement. We keep the Quarantine Officer informed of all details of arrivals. He will take or he will allow to pass whatever ships we want. He even carries his cooperation to the extent that he will take them in order if we want them.

We found it very helpful to keep in close check with them. In addition, bringing him advance warning will enable him to get advance notice. We found that three-way, close liaison among the Navy, Army and Quarantine Service has been very helpful to us.

LT COLONEL FARR:

There are no more questions? Thank you very much, Doctor.

We have always heard very fine things of the set-up here in New York, and I am sure after hearing Dr. Olesen you can appreciate why it works as well as it does. He has a wonderful grasp of what is going on.

There is no service outside of the War Department that is so closely tied in with the operations of Transportation on inbound troops as that of Public Health Service. I have been in the job of moving troops for the past several years, and during that time we have had several emergencies. They always come up six to twelve hours before sailing. You name any port and you will find some of them. We always had the finest of cooperation from Public Health Service in finding ways and means of getting around these emergencies in order that our troops may move. Any organization reflects the character of the head of that organization in its functions, and I'd like to present to you at this time the Surgeon General of the Public Health Service, Dr. Parran. Would you care to say anything, Doctor?

DR. PARRAN:

Colonel Farr, Gentlemen: If I may say, I should like at the outset to try to summarize and sharpen up some of the points that have been made by Dr. Olesen in his discussion. I think you can assume the fullest wish to cooperate in dealing with these mutual problems among the Army, Navy, Maritime Commission and the Public Health Service.

Listening to the discussion thus far, I am not sure that all of you especially the operational line officers, grasp the limitations and the scope of authority of the quarantine laws. I need to go back in time to a situation which existed in preceding generations whencommence among the nations of the world was being blocked by arbitrary and discriminatory action on the part of the Health Quarantine Officers against nations with which they were not friendly. So a series of international quarantine conferences were held resulting in certain covenants which were entered into among all of the major nations, and, I may say, practically all of the nations of the world. The theory underlying these conventions is that the Quarantine should not be a bar to international commerce, but that measures should be like, as Dr. Olesen has said, a sieve, a sieve which can be made more coarse or fine, depending on the particular disease hazard.

However, it was agreed that Maritime Quarantine would not operate against all communicable diseases. The scope of our quarantine laws and the provisions of these laws are limited by treaty obligations, applied to certain of the more dangerous communicable diseases. Dr. Olesen has named them. The laws do not apply to any communicable disease. However, in this country and in most nations of the world, regarding quarantinable disease, the power of a Public Health Service today is absolute; specifically against plague, yellow fever, typhus, psittacosis, cholera, small pox and anthrax; and all of the civil police power of the government can be brought to bear to prevent introduction of such diseases,

whether they be transported in military or civilian ships or planes. The laws give to the Public Health Service complete authority of enforcement and authority to call the enforcement agencies of the government. In other words, under the law, the Army or the Navy has not the responsibility of preventing the introduction of a quarantinable disease. That resides in the Public Health Service. Now in time of war as a practical measure, very clearly the Surgeon General and Transportation Services recognized the situation, the need for secrecy in the movement of Navy and Army ships and planes, and agreements were entered into. These agreements are somewhat different, as the one between the Air Transportation and the Transportation Services.

As regards air transportation, it was agreed that at each airport of entry, each Army or Navy airfield to which planes would come from foreign lands, there would be nominated to us and appointed a medical officer of the Army or Navy, whose responsibility it would be to act in the enforcement of the quarantine laws. In other words, we agreed that the Public Health Service should refer to the respective services the responsibility for carrying out the quarantine laws. It obviously implies a knowledge on the part of the individual medical officer concerned, of these laws and regulations.

As regards the ships, the problem was more complicated, because there has been indicated here strictly military and naval craft. There are craft belonging to the Maritime Commission under the Army and Navy, some of which had a certain amount of civilian shipping. Perhaps our instructions up to now have not been sufficiently definite. I think a conference like this is very helpful in trying to clarify our procedures. However, after listening to the discussion this morning I get the description of disinfestation as a practical method. However, I should hope that before this conference breaks up, we can have some hope that before this conference breaks up, we can have some general agreement as to what are the most practicable ways of insuring against the introduction of quarantinable diseases - I emphasize that adjective - and second on seeing that the movements of ships are not unduly delayed. It is obvious of course that it is necessary to minimize the delay in the movement of ships in these times. The plan which has been worked out and is being worked out here in New York seems practicable. It is gratifying to know

how comparable other plans in effect at Hampton Roads or San Francisco and other ports are. Yet since the problems are common, I should hope that rather uniform and standard plans can be worked out under which not only would we be assured of cooperation in exchange of information, but under which plans the respective responsibility of each agency is clearly set forth, having peculiar to the Army and Navy the responsibility in connection with ships under their control. I will emphasize, especially to the operational line officers that you, the Army, are assuming thereby a very real responsibility. It is easy for us to say we wash our hands of this, and turn the responsibility over to you. That isn't quite the way of doing the job, it seems to me. Some of our quarantine measures in the past may be outmoded. We have tried to keep pace with the scientific developments in epidemiology and disease control.

I thought Dr. Olesen seemed somewhat apologetic about giving up Ellis Island for detaining people. I hope in peacetime we shall never need a type of place of detention such as that. The most economical place is aboard ship. Under modern conditions in case of quarantine disease, provisions may be made for care at our Marine Hospital at Staten Island, and beds are always available there for that purpose. Again, having disbanded disinfestation facilities here, the Army has established disinfestation facilities, obviously not being economical to have those facilities duplicated between Army and Public Health Service. That's part of the arrangement, namely, that your facilities should be available for this purpose.

Dr. Olesen has emphasized and I should like to underline that our strategy against each disease, that is against the rat, primarily, is to fumigate every ship that comes in, and to build that fumigation on the ship; and that can be done; and a detailed inspection made of each. That makes it impossible for rats to find a comfortable home aboard these ships. We have been able to keep constant track of the sanitary conditions of these ships that come to any of our ports, and even more, were able to keep a global map as to where each ship is, or was at any particular time. At this particular time, obviously that is not possible; therefore we need to depend on other measures. So much for the quarantinable diseases.

For the non-quarantinable diseases, many of which are more serious possibly than those listed as quarantinable, the general procedure suggested would be: One, to keep track of the conditions at foreign ports; two, to see that the sanitary conditions at our port of arrival and our health organizations here are adequate to prevent major outbreaks; three, to observe the presence of such communicable but non-quarantinable diseases and to notify the public health officers and the jurisdiction concerned of this purpose.

It is a deliberate policy. I represent that this nation and other nations do not exercise their national authority of quarantine against any and all communicable diseases. I know you have had discussions of some of the problems of combat of anopheles, aegypti and other things. They will be coming back and will be important, but I think this is not the time to go into it.

Before closing, I should like to say that early last winter three of us and the Surgeon General discussed this general problem with particular reference to the changes that have been brought about and will be brought about as a result of air transport. We agreed that there probably were some holes in our armor - that of the possibility of carriers of yellow fevers coming back from West Africa or some with the diseases from the Southwest Pacific.

As a result there was appointed, with the approval of the President, an inter-departmental quarantine commission composed of medical officers of the Health Service and the Army and Navy. Colonel Lundberg was the Army representative, but because of other duties he had, it was necessary for the Army to name an alternate in his place. That Commission has been riding the airlines north, east, south and west to see what the conditions are.

The recommendations of the Commission, in effect, are to investigate the problems of the transmission of disease, both between such foreign bases and other countries in such hemispheres, and between either of such places and the United States. The Commission is charged to recommend changes of law and regulations in order to insure, as far as possible, against the breeding of disease as a result of military operations, and especially air transport. There have been some outbreaks in our Army. The recent outbreak in Hawaii is a good illustration. Recently it appeared. Fortunately, perhaps the epidemic has had a wholesome effect in the stimulation it has given to ideas of control there, which control public health indicates all of you don't know.

The second break in our armor occurred between the west coast of Africa and the eastern side of Brazil. You will recall that in the early thirties, the French established a trans-Atlantic Air Line. This Air Line is said to have introduced in South America the mosquito anopheles gambiae. From Natale, the mosquito spread over large areas. This mosquito is a very vicious vector of malaria.

It just had not been known in the Western hemisphere prior to its introduction, but it took root and spread widely. It caused severe and devastating epidemics of malaria. In one large cotton area there was complete loss of crops because no one in that area was on his feet to pick the cotton. As a result of this condition the Brazilian Government spent three or four million dollars. The Rockefeller foundation contributed about half as much. That joint effort accomplished a remarkable result in regard to sanitation in that area. For the first time, a species was completely exterminated over a large area. Naturally, the Brazilian government is very sensitive about the introduction of that vector of malaria, especially since it has found on Army Transport Planes, on a number of occasions, anopheles gambiae. The dates and planes are a matter of record which have been reported to my office. They have found down there on several occasions the tsetse fly vector of African sleeping sickness. I wouldn't want to put this on the record. Perhaps they have been reluctant to have the snooping Brazilians examine their planes so meticulously, but I assure you that this examination is necessary. Within the past two weeks a report has come which is even more disturbing, namely, that the Brazilian health authorities have found in the Navy Officers Club in Natale a number of anopheles gambiae. The story has broken in the Brazilian press and is a serious international incident. The matter is naturally being taken up aggressively between the Secretary of State and the Secretaries of War and Navy. It is a matter of imminent concern on the part of our medical service. Fortunately, our Quarantine Commission at that time wasn't in South America. I anticipate as a result of their study of that particular situation we may be able to insure against that outbreak in the Army. There is another dangerous area in the Carribean. We have expected and looked upon the Carribean Islands as barriers against the introduction of yellow fever, yet the conditions in many of those islands are very favorable to the spread of yellow fever should it be introduced. Yellow fever is endemic in the jungles in a large area of South America, and for that matter is endemic in all South America. The Carribean Islands instead of being barriers have become sea beds from which we get further trouble, further impairment, delay in introduction of wartime transport. These problems are all part of complicated field operations which are of concern to you. I wish, Mr. Chairman, that I could have been more adequately prepared this morning and had not had to come in cold as I did.

LT COLONEL FARR:

Thank you very much. Those thoughts are most interesting and fit in very well with the rest of our conference. One problem raised by Dr. Parran was the problem of control. You have your local committees. Some of you don't have such strong committees. Dr. Parran, how would a committee in Washington, made up of the Public Health Service, the Surgeon General, the Chief of Transportation, the War Shipping Administration, the British Ministry of War Transport, Navy and Air operate if it were established to coordinate with committees of various ports?

DOCTOR PARRAN:

Mr. Chairman, my first snap judgment is that perhaps we should await the return of our Inter-departmental Quarantine Commission which will be back in a few weeks, and study their recommendations. Perhaps their recommendations will not be made until further conferences are held in Washington. I think it is very possible that such a group as you suggest might be set up under the combined Chief of Staff as a temporary group to advise in reference to certain specific problems which will be raised by the Quarantine Commission when it comes back. I am conscienciously loath to recommend additional committees in wartime unless they are to be temporary committees charged with specific responsibilities so that they can get their jobs done and then disband. Colonel Lundeberg, have you any comments to make?

LT COLONEL LUNDEBERG:

I agree that the Quarantine Group who will be back in a few weeks will be in a much better position to advise us on this matter.

LT COLONEL FARR:

The best thing to do at the present time would be for our Port Surgeons to cooperate with the local public health authorities in forming such a local group. Dr. Parran, would that not be the best immediate step to take where such a committee is not in effect?

DOCTOR PARRAN:

I think that would be a clearly indicated step. Each group, however, should understand its responsibility.

LT COLONEL FARR:

I am sure that your Ports which do not have such a committee will take steps to take care of that mattor when you get back. Are there any other points which you would like to raise before we go into discussion on previous presentations? (Pause) I see there are none. We will start in with some of the questions that have been brought up and which were handed to me last evening. I am going to leave this matter of a committee to work on the Transport Regulations until last, because we have a committee established to work on that and unless you have some questions, we will take it last.

I would like to ask those of you who are going to enter into this discussion, particularly those in the back of the room, to speak up loud enough so that the minutes may be taken because the reporters have difficulty catching some of the faint whispers from the back there.

Now, point number one, is the matter of how many troops we can carry on a vessel before that vessel can take a doctor on board. Hampton Roads proposes that 350 soldiers would be required before taking on board a medical officer. Where the number of soldiers are smaller than that a trained medical technician should be supplied. This technician should be supplied. This technician can be trained in accordance with the recommendations by General DeWitt.

Another recommendation is that all ships carrying 250 men or less have a qualified enlisted man - medical attendant instead of a medical officer. It is further recommended that the school proposed by General DeWitt be established.

We have from two ports a recommendation that we use enlisted personnel only on those transports, that our Transports Surgeons' Manual either be supplemented or have a particular specialized section. Should we or should we not have a separate set of instructions for enlisted men when no medical officer is present?

COLONEL BRECHEMIN:

We have quite a number of cargo vessels employed in Alaskan trade but we don't have many ports to stop at. We always call at the Coast Guard Installations on the inland run, and that has saved us the services of a great many medical officers. Occasionally we have commercial liners with from 50 to 300 or 400 men. We would like to have a general agreement of the actual number required to put a medical officer on board. I was always afraid that something would break out

on those boats, and I would be held for not having a medical officer aboard.

LT COLONEL FARR:

I think the number is going to have to be definitely stated by the Surgeon General's office. We can make a recommendation. I think we should make a recommendation at this conference, but it will have to be confirmed or changed by the Surgeon General. We have 250 and 350 recommended. Does the conference feel that we should recommend 350 as the dividing line?

LT COLONEL FEISTEL:

May I suggest that the length of the voyage also be considered.

LT COLONEL FARR:

That is a very good point. It complicated the problem, but I think we will have to consider it. If you have a five-day voyage, you are not going to run into the complications that you will run into with a sixty-day voyage.

LT COLONEL SEARLES:

I might suggest also that the overloading of a vessel be considered. You might have 300 men on a vessel that would normally carry one hundred. Undoubtedly you would need more medical attention in that case from a layman's standpoint, whereas in a boat which was not crowded you might get by with an enlisted man.

LT COLONEL FARR:

I guess that is another factor that has to be considered.

MAJOR GAY:

Seattle has a little different problem in that they use an inter-waterway. They have this problem. These men may be out at sea, maybe 4 weeks, 6 weeks or more and out of touch with any instruction of any kind. The emphasis should be placed on the training of these men.

BRIG GENERAL DE WITT:

It seems to me that we have to approach this from the standpoint of available personnel and the problem is for somebody in the Surgeon General's office

to decide what the maximum number of troops is that we can put on board ship without a medical officer, and then for us to meet that problem and that problem is training personnel. Now we have in service excellent technician schools. We are turning out surgeon technicians, medical technicians, pharmacy technicians and laboratory technicians, but what we need is some man with all those qualifications and we haven't got him. If we are going to meet this thing intelligently we've got to train these men. Certainly the training will have to extend much longer than it does at the present time. I think we can meet that problem.

LT COLONEL FARR:

May we make this recommendation from the conference to the Surgeon General - that a school be established or that qualified men be trained. The exact dividing line will have to be decided at a later time.

COLONEL MELTON:

I am afraid that we are giving the impression to public health that we don't have any trained men. Commander Terwilleger has said something about the training that is taking place with the Maritime Commission, and these men are likely to substitute for some of the men that we are trying to train. I am highly in favor of the school, but that is a four months course, what are we going to do in the next four months?

COMMANDER TERWILLEGER:

Mr. Chairman, as far back as a year ago the Public Health Department in cooperation with War Shipping established a school at Sheepshead Bay. There is a Maritime Training Station there for the sole purpose of training what we call hospital foremen. We train from pharmacist mate to hospital foreman purposely, because pharmacist mate is a hangover from the old horse and buggy days from which we carry with us the idea that pharmacist mate is an assistant to a doctor or a man who is entirely confined to a pharmacy and dispensing medication under the medical officers advice. Therefore, we chose the name for our graduates from that school, the Hospital Foremen, because their training went beyond the so-called pharmacist mate.

The requirements for these men is rather high. We set an I.Q. test for them during their indoctrination which compares to the IQ. required for a boy entering a radio school or any of the special training divisions of War Shipping. A lot of these men have had medical background. They have been boys who started in pre-medical school and because of the urgency of manpower or financial reasons after two or three years have had to change their course. They want to serve their country and have enrolled in our hospital course school. Briefly those are the prerequisits.

The course in training is 25 weeks and during that 25 weeks they are given an introduction into the basic sciences of medicine, courses in anatomy, phusiilogy, chemistry. We keep in mind at all times that we are not training professors, that we are not training medical men, that is physicians, but we are training so-called medically trained technicians, a group of men which here in the States of New York and New Jersey enjoy a license to render first aid under the rules and regulations of the States of New York and New Jersey. According to the standards of the Navy, they are recognized by the Navy as qualified men to render advanced first aid, medication, treating of minor surgery, treating of traumatic injuries, etc.

In addition to medication, these men are given practical experience in actual bedside nursing, they are given practical experience in operating rooms as far as a trained attendant should go, treating wounds, dressing, giving hyperdermic, intravenus therapy and last but not least, trained to complete innoculations for immunization which should be carried on while these men are in transportation. It is our plan that everybody should be working on it to have it in the very near future, I think by the very first of January.

We have made separate rules and guide books for these men which they take aboard the ships. It is parellel to our Ships' Medicine, but is written in terminology which these men can interpret and in which we also give them a guide as to just how far they can go. They are not surgeons. They are not to go beyond their range and there are limitations. Our guide book of instructions tells us what their duties are and what their relationships are to other officers aboard the ship.

Then the second largest group, the care of sick and wounded aboard our ships. The course is 25 weeks. To date we have graduated over 800 men and we are graduating approximately 50 a week. We hope to run this number up to 4500.

In addition to the hospital training they take another month in the Sheepshead Clerk's School. There they learn the routing of a ship's clerk. This was done by the request of almost all of the shipping companies because a liberty ship operating in war times, has very little work for ship's clerk. He might be busy two hours per day, but on the long run, he has nothing to do in the meantime.

Space in the liberty ship is scarce and we don't want to increase the complement of the ship unnecessarily. The minute you increase the complement of a ship, you increase the demand for lifeboats and if you increase the demand for lifeboats on one side of the ship you have to duplicate it on the other side. If you put on one extra man, sometimes it means putting on two extra lifeboats. So we have started this combined course.

LT COLONEL FARR:

You say you are going to put this on all W.S.A. vessels. What will their relationship be to Military Personnel if and when Military Personnel are carried on that ship? Will it be acceptable for them to replace medical personnel of the Army?

COMDR. TERVILLEGER:

They would replace medical personnel of the Army to the point that they would replace a trained attendant in the Army, but they won't replace a medical officer of the Army. We would be very happy at any time to cooperate with Army personnel that needed medical or surgical care.

LT COLONEL FARR:

I think that is something that is going to be of immense value not only in pattern, but from the standpoint of actual health. You are primarily interested on conserving doctor personnel; you feel that this conference should go on record as recommending steps be taken to get such type of enlisted personnel for you.

LT COLONEL PADDEN:

It boils down specifically to a personnel matter. It is a planning and operational matter. I am primarily concerned with the non-availability of doctors. There will be no alternative. Somewhere, somehow, we have got cut. We know it is not desirable, but we are faced with the proposition of reducing doctors. As I mentioned yesterday, it is so serious that consideration has been given to recommending the removal of the second doctor from a combat battalion on the front line, that means men in combat with one doctor. That is the

reason we brought it up. It is being considered by everybody in the Surgeon General's Office to arrive at some reasonable figure as to how many doctors we can use. This same question has been brought up repeatedly. The medical technicians weren't broadly trained and that they couldn't step in. We admit, all of us, that we have excellent medical technicians, surgeon technicians, but they are specialists.

LT COLONEL FARR:

I believe that all our Port Surgeons agree that it is possible to replace doctors on these small vessels. I would like to be sure of that and see if anyone disagrees.

LT COLONEL WHITE:

There is one thing I would like to bring out. What would be the minimum number aboard a freighter with which we would have to supply a trained technician? We send a lot of freighters out with 5, 10, and 12 enlisted men on board.

COMDR. TERWILLEGER:

In the Navy in peacetime if you have 40 or more men on board ship or even 5 or 10 men, whether that number be military personnel or whatever, they have to carry some form of medical aid on board. To date we have over *** men assigned to sea duty with the ********Line, the ********* Line, the ********, and the ********, 60% of the lines operating out of the Port of New York and we are beginning to get back what we call "fan mail". We are getting very good reports on these men to date on work that they have done.

Now in setting up a school for the Army, I would like to make one suggestion. In preparing your courses, don't try to make professors out of these men. 90% of the men ill at sea need good nursing care. They need to be made comfortable, proper diet, if necessary, men should be given proper nursing care until their return to their home ports. 90% of these men will make excellent recoveries, but in training the young men, and these boys are young men, you always have to tone them down because they want to do things dramatically. If you impress them with the idea of passing on the milk of human kindness to their sick buddies, it does a great deal on board ships to build up morale.

COLONEL MELTON:

I know this training has been taking place here for some time. I want to suggest that we ask Commander Terwilleger's training section to supply our training section with their program, which might be a help. Of course there are more or less specialists. I would like to go on record as asking Commander Terwilleger to send to each Port Surgeon this book of instructions that they had issued for each ship. We can use that in compiling our instructions for any of our technicians that we may want to put on these ships. Now their training is 25 weeks. Ours is presumed to be not less than 12. Is that right?

BRIGADIER GENERAL DE WITT:

Yes.

COLONEL MELTON:

I am sure that in 25 weeks these men can be trained to look after ordinary illness on board ship whether it be military or naval. I would like to see a number established as a solution to this particular problem. There are too many factors involved and I'm afraid that the responsibility of our Surgeon General toward protecting the lives of our troops will be hazarded under certain circumstances. I feel that the decision of adequately trained medical technicians or a doctor on board any given ship must be weighed out in each individual case and that responsibility can be settled. Probably in the port. Further they are reluctant to see troops of 100, let us say, ship anywhere over any period of time without the services of a doctor. Now 500 men can be shipped from New York to England in **** days and run no risk. 100 men from San Francisco to India may get into all sorts of trouble. I think you have to weigh the physical condition of those troops at the time of their clearance. The season of the year must be considered, a provilence of respiratory diseases and all that sort of thing. Now if of the 100 men you send out, fifty get very sick and ten die, the Surgeon General is going to back to our people and he will say that he has made adequate provision for the protection of their health.

We have heard the subject mentioned of taking calculated risks. I think we must carefully calculate our risks. Also I would like to see some studies made with reference to the matter of taking out our calculated risks in the transportation of troops on trains into zones on interior.

There we have a network of medical facilities, there the time factor is very much shorter; and there at present, judging from my own experience, we also have a large number of surgeons constantly tied up traveling all over the country. There I think that we can take our risk and one way or other save those surgeon manhours and devote them to the ports where these questionable coverages could be made to any body of troops, from 100 men up, depending again on the length of the run, the physical conditions of the troops and the season of the year. I would again like to repeat that I am reluctant to see troops at sea in any number without the services of a doctor. I think coverage can be made at the same time not running against the requirements and the inevitable circumstances with which Col. Padan has stated on the matter of furnishing doctors. I realize that that whole subject is complicated, but I would like to have it go on the record and hate to see an arbitary picture set up.

LT COLONEL FARR:

With reference to the minimum number of men that could go out on a boat or ship without medical attendance of any kind, we have had a conference with Colonel Fitzpatrick who leans on 250 as a dividing line.

COMDR TWILLERGER:

The only satisfactory solution would be to put a doctor on each ship. That is impossible. The problem will have to be met by compromise and all we are going to decide is the level of the compromise. I would like to say also that the Port Surgeons have small operating services and have had made available to them the staffs of experts on service commands. I might state that these surgical, medical, and sanitary consultants are there for the purpose of helping the Commanding Officers of the station hospitals to solve their professional problems along these particular lines within that service command. In this particular event, after suitable arrangements have been made between the Port Commander and the Surgeon and the Commanding General of the Service Command, these consultants can be made available to the Port Commander. I believe that any report that these consultants make should be sent to the Port Commander for his information. Naturally, it can go to the Port Surgeon.

LT COLONEL FARR:

That is the understanding that General Kirk and General Wylie had last week - that it should be made available to the port commanders.

I think it will be very helpful to the Ports. I know that some of them have already made some arrangements quite successful, others have not. We would like to have you go ahead locally with those arrangements. I think we ought to finish up what we were doing, that is, in the matter of personnel other than doctors on the small vessel. I think that we are all agreed now that it is practicable, not desirable, but probably will have to be done. I am wondering if there is any further action to be taken by this conference in covering that particular point. Colonel Schwichtenberg, do you feel that we should make recommendation as to the size - should we leave that up to the Surgeon General's Office after they have explored the possibilities of furnishing capable personnel?

COLONEL SCHWICHTENBERG:

I believe that General Bliss' idea was that we should get some expression of opinion of the Port Surgeon as to what should be done. I believe that you already have that in these reports that you got from most of them last night. Anything you have done is going to be predicated upon the absolute non-availability of officers. That is something that we just cannot get around.

LT COLONEL FARR:

We do have from at least two Port Surgeons on record here, their recommendations, which Colonel Bradish has made. Is there anyone else who would like to make his recommendation at this time? If not we can drop this matter as having been covered.

LT COLONEL LUNDEBERG:

May I say as an outsider, that since 6 months training will turn out 4500 men, why can't we use some of those men?

LT COLONEL FARR:

I have an idea that the War Shipping Administration could train these men for vessel work for their own and not lend them to the Army.

COMMANDER TERWILLEGER:

I think, the only way we could help out is purely in an advisory capacity, you have a lot of technicalities involved. First of all, these men who are trained by War Shipping funds would have to be placed on War Shipping vessels operated by War Shipping Administration.

I'm afraid that you might subject yourselves to severe criticism if these men were to go on boats other than those operated by the War Shipping Administration. If we can help in starting up your school in any way or lend any of these men as a training project, I think that would be alright.

LT COLONEL FARR:

He is not going to give away personnel unnecessarily.

LT COLONEL PADAN:

What I meant, Mr. Chairman, was if the ship was one not staffed by War Shipping personnel. When it is a question of a foreign crew or a ship on a charter, then assigning these might be criticized. We are operating solely under WSA shipping.

LT COLONEL FARR:

That was my understanding.

LT COLONEL PADAN:

I would like to make another remark here. The thing that we want to arrive at primarily is a policy that the Surgeon General of the Army recommend, with a statement that if doctors were available, that would be from casuals going overseas or from rotating personnel coming back, that those should be utilized. What we are talking about now is a certain fixed minimum that we know that we would have to provide taking no chance. These 50% chances that a lot of the boats going out have a certain number, that casual doctors might be placed on the boat - what we are talking about is the absolute fixed minimum number of doctors we must provide, the same with the number of enlisted personnel. Then another problem comes up that some of these boats don't carry people all the time. Sometimes they carry freight and sometimes they carry passengers. We have to know for planning purposes the maximum number of doctors that we will provide the COT, and he will have to use them in accordance with the procedure established. We don't want to put a thing saying, "You wouldn't put a doctor on a boat smaller than a certain size". But we want to arrive at the point that a doctor must go on a boat of a certain size, and anything smaller than that he should be put on, if available.

LT COLONEL FARR:

I think that is a very good clarification.

COLONEL BRECHEMN:

Don't you think then that we ought to recommend a certain figure like 250 that will not require a medical officer below that number based by your judgment on the length of the voyage and when you place the enlisted men on board? We have to have some sort of a guide.

LT COLONEL FARR:

Does anybody object to such a recommendation? 250 and over must carry a medical officer. Are there any objections?

LT COLONEL PADAN:

From the information I have, there are a large number of ships involved on that and as I get it there will be an extremely large number that will carry over 250, but as I understand it, these ships by no means will carry personnel all the time. Sometimes they will carry freight. It is the delicate situation of allotment, and it must be considered because the COT must have the exact allotment.

LT COLONEL FARR:

May I interrupt a moment. Dr. Parran has to leave now, and I want to thank him very much for his help.

DR. PARRAN:

Thank you, Colonel, for the opportunity of being here.

LT COLONEL FARR:

We have that at 250 and over. Shall we modify the word to "should" or "must"? Colonel Brechemn, you started this.

COLONEL BRECHEMN:

Well, I would like to have it as a guide.

LT COLONEL FARR:

Would you have it "should have" or "must have"?

COLONEL BRECHEEN:

I would modify that to "should have" but you can leave that to the personnel.

LT COLONEL FARR:

250 and over should have a medical officer on board. I see no objections, so that will be the recommendation of the conference. Now there is one point I would like to raise very briefly on the manual, instruction, or guide, whatever we decide to call it, for Transport Surgeons. Should it be made to cover hospital ships?

COLONEL BRADISH:

In my opinion, no. I think that with the various outstanding instructions, wartime circulars, army regulations, and existing technical manuals, there will be adequate material upon the Transport Surgeon can work out the internal administration of his vessel. I think that the numbers of these vessels are not so great, but that it will be perfectly possible directly from the COT office, for Col. Fitzpatrick to promulgate certain policies with reference to debarkation procedures, etc. That will make the mechanism of the operation of these vessels uniform in these ports. Beyond that it would seem unnecessary to go.

LT COLONEL FARR:

I think you are absolutely right. Is there anybody who disagrees with Colonel Bradish on that point?

(No response)

LT COLONEL FARR:

That will be it. Here is a question. What is the proper disposition of personnel removed from task force units because of physical defects on whom operative or other procedures are not considered feasible in order to rehabilitate them? Should they be C.D.D. in the staging area or returned to previous stations for disposition? Who wants to answer that?

COLONEL SCHWICHTENBERG:

I am afraid I will have to answer that the best I can. In my opinion, the only answer we have to that is that if the staging areas have the facilities available in their immediate installations, they should be C.D.D. on that point. If, on the other hand, they do not, some consideration should be given to sending them back to their original stations.

However, that is going to involve considerable transportation in many instances and therefore thought should be given to having that done in more local areas.

LT COLONEL SCHUHMANN:

May I say something on that Colonel? It adds a tremendous administrative difficulty to do that in the staging areas. The staging areas, in the past, have always acted more or less as a dumping ground, I do believe. I don't know if that is also the opinion of the other ports. I believe these people should go back to their original station, for this administrative work.

LT COLONEL BERRY:

That question is apparently split into two parts. One; the people not fit for further service and are to be discharged, and the other, the borderline cases to be rehabilitated. In the 2nd Service Command at the present time, we are promulgating a directive on the question of rehabilitation. The England General Hospital at Atlantic City has set aside a large number of hospital beds in one unit known as the "Rehabilitation of Convalescents Unit" of that hospital. We have in mind transferring from any station within a service command cases which will require long convalescence and cases which are borderline in nature, for discharge consideration such as symptomatic flat-feet, scoliosis and symptoms, borderline psychoneurotics and cases like that. That may be part of the answer to this question. We are also at the present time working out a tentative plan for a pilot station, at which discharges may be consummated particularly from small posts. There is nothing definite on that yet, but we are working on the idea. At the small station he will get the C.D.D. and they will transfer him to this pilot station and there the final administrative action in connection with his discharge will be consummated including the writing up of the Medical Board's finding; the adjustments of final pay, entries in his service record, and all the rest of it.

LT COLONEL FARR:

From the standpoint of staging areas, Colonel Schuhmann has a very strong point there. A staging area is not a place to hold people. It is an in-transmit camp as the British call it, which I believe is a little better description. Its whole purpose is for a final inspection to see that something hasn't got by previous inspections. It should not be

a rehabilitation center. Our staging areas are small compared to what we need. We have a demand on the East Coast here for approximately 50% more staging area than we have at the present time for peak loads. We just cannot afford to keep in those staging areas personnel who have no legitimate right in there. We are lending every effort ourselves, and I hate to differ with the Colonel here (indicating to Colonel Schwichtenberg)--

COLONEL SCHWICHTENBERG:

That's all right.

LT COLONEL FARR:

--but we are putting every effort in our directives to make it possible to return these men to the station from which they came. In many cases, Colonel Berry, it goes back to the service command that did not do a thorough job in the first place or perhaps something slipped by. I don't believe the service commands actually want the ports to take over the job that for some reason got away from them. I don't believe that that is their intention, do you Colonel Berry?

COLONEL BERRY:

No, but that brings up a question. Suppose a man is inducted from New York and he is sent to Camp White, Oregon, and had his training there, and then his unit was staged back through an eastern staging area. It would not make much sense to return him to Camp White to be discharged and then brought back again to the East Coast. In all those cases, every factor should be considered. It is the question of conservation of transportation in keeping - say if he was in the service command of his residence - making some disposition within that service command instead of shooting him out across the country.

LT COLONEL FARR:

Of course, there is another feature of this thing. You have a very good point there. One, I think as Colonel Schwichtenberg suggests, anything we set up cannot be so iron-bound that we can't make exceptions in those cases. We have had in the past difficulty in station commanders sending personnel in, obviously unfit. We have had some difficulty in getting forcibly to the attention of those station commanders that fact. It is felt in G-1 of the War Department that one of the quickest ways to bring them in line is to send some of this personnel back to them, and that is what we have in mind. However, in answer to this specific question, should they by C.D.D. in staging areas be returned to previous station? They should be returned to their previous station but regulations

are not such that they can be. You stated specifically, task force units. I believe that present regulations do not permit sending personnel of task force units back, but do permit sending back personnel from replacement depots. If it isn't out yet, there is a regulation being made to cover that. We are at a critical situation in staging areas, and I presume the staging area hospitals reflect the same condition that the staging area does.

COLONEL MELTON:

The 2nd Service Command has a replacement depot. We don't.

LT COLONEL FARR:

It is a new regulation and maybe it is not out yet.

COLONEL BERRY:

There is one thing about getting men out of general hospitals who didn't come from staging areas.

LT COLONEL FARR:

This is more or less a rider, stuck in something that doesn't particularly apply to that particular matter. I have another question here. In view of the fact that uniform instructions could and should be issued to Transport Commanders. Would you like to say something about that, Colonel.

LT COLONEL BRANSTATER:

I think there should be uniformity of instructions to Transport Commanders.

LT COLONEL FARR:

It looks like we have cause for another conference.

LT COLONEL BRANSTATER:

I think the eastern seaboard here has relied on instructions which are fairly well light.

LT COLONEL FARR:

Another question. Is there a central agency from which to secure data on troop transports or troop carriers, showing such information as total troop capacity, number of compartments by deck, number of staterooms and capacity of each, number of gangplanks that may be used, draft load availability of compartments for accommodations of nurses and WACS, a shelter for standees.

That question is presumably directed at me. We have some of this information in Washington centrally; not all of it. Most of it is information that is available in the Troop Movement and Water Divisions of the various ports. When you have a new vessel coming into your port that you have never used before and you wish this information on it, if you will check with our office, and we don't have it - we wouldn't have all of it - we will refer you to the last port that loaded it. There is a peculiarity of ships that I think Colonel Feistell will agree with me on, that they never come into a port with the same amount of space available twice in succession. Any information you get is going to be approximate, although it will be a reasonably close one, but we will put you in touch with the port that operated the vessel last in each case. Does that answer your question, Colonel?

COLONEL REXROAD:

Yes, sir, it does.

LT COLONEL FARR:

Another question. What steps have been taken to see that all Liberty Ships which are to carry troops through cold areas have heat for troop quarters?

Our information at present indicates that very few are so prepared. WSA takes the position that south of 36° heat is not needed, but north of that line, it will be necessary in the winter. We are going ahead - when I say "we", I mean jointly the WSA and the Army with the WSA doing the work of course - are going ahead and heating all of these prisoners of war conversions. How rapidly that is progressing I don't know. Do you know Colonel Feistel?

LT COLONEL FEISTEL:

I understand they have ordered about 200 units and as these ships come in here they can be put in place rapidly.

LT COLONEL FARR:

It is not a long job as I understand it, and it is our expectation that these vessels will all be heated shortly. As to whether you need heat at 36° or south of 36°, I don't know, but we are heating everyone of these or making it possible to heat them, so that proper conditions will be able to be produced.

We have another question raised here - that has to do some what, I believe, with this industrial medicine, and yet it isn't exactly that. That is the extent of the immunization against typhus. The extent that each port is to go in taking care of port personnel. As I understand it there is a directive out that all personnel working permanently with ships, or loading ships, or come in contact with ships, that they will be immunized against typhus. New Orleans has run into a very peculiar situation down there, but I believe Colonel Bradish can tell you better than I can.

COLONEL BRADISH:

A directive that came from, I believe, The Surgeon General's Office, that is the guide to protect ourselves against typhus in my opinion was clear enough, and it said those personnel permanently employed on the vessel would be immunized against typhus, which of course would mean the crew and all the civilians and all the military and naval personnel who actually go out and board the vessel. And, in addition the port personnel who work on that ship and have contact with troops should be immunized. After all the idea there is to protect against the introduction of typhus and keep them from being affected by it. I am after information this morning from anybody else as to what the hazards are in this connection and how far we have to go. The problem with us is not prisoners of war as far as New Orleans is concerned, it is not a problem at all because they come in and handle their own baggage. We think it is fairly well confined. When it comes to delousing returning troops who come back with personal baggage, and also in the hold there will be loaded the well known "B" bags, and those will be our problem. Now, our contracts require that handling of our baggage by the stevedore contractor. Colonel Lundeberg expressed the opinion that there is going to be considerable danger involved in the handling of those bags. Now, we have in New Orleans an old system which presumably goes back to the river boat days, whereby all longshoremen labor is recruited from a pool of colored laborers -colored longshoremen. By the way, stevedores are very touch about being called longshoremen. There is a difference. A stevedore is a man

who contracts for the labor and furnishes the equipment for the unloading of vessels. Longshoremen are the laborers. That pool involves over 4,000 colored laborers -- the foreman whom the stevedore contracts for a gang, picks up his laborers and he usually has nearly the same group. But the same gang doesn't necessarily work on the same vessel at any given installation. They may bring different gangs to the army piers on every different occasion, because they're always slinging jobs all up and down the waterfront for commercial vessels and otherwise. Now the question is, is it safe to allow these longshoremen, if it is not practicable to vaccinate them, to handle the "B" bags out of the hold? Then the question is raised why isn't it practicable to vaccinate them, other than because of the numbers involved, which is very considerable, and we still can never be sure we have got them all. There seems to be a peculiar psychology involved the minute you start requiring a vaccination of that type of labor, which is strongly unionized. It may be considered performing extra hazardous work and the factor of time and a half comes in just as it does in the matter of loading ammunition. The stevedores feel that they will be very badly handicapped in the inability to persuade the colored laborers to take the vaccination, and it may be that they won't join the gangs when we need to go out there in the unloading operations. Probably the solution lies in attempting to immunize a company out of a port battalion to handle this particular feature. I am curious to know whether any other port has a similar problem, and I would like expressions of opinion as to how likely it is that longshoremen handling baggage would be infested with lice.

LT COLONEL FARR:

Colonel Lundeberg, do you want to comment on that?

LT COLONEL LUNDEBERG:

I talked with Colonel Bradish about this last night. I am inclined to believe that perhaps they should be vaccinated. Furthermore, when you consider that we are probably emphasizing this typhus hazard pretty heavily, I begin to wonder if it is not carrying things a little bet too far. I don't know enough about the developments to know how much danger there is from those "B" bags. What have you to say about that point, Lt. Blanton?

LT BLANTON:

The first question that comes to my mind is how long are those bags in that hold before the personnel handles it?

LT COLONEL LUNDEBERG:

From a week to two months.

COLONEL BRADISH:

On the average the period is shorter than 30 days, and I believe the lice don't breed within 30 days.

LT COLONEL LUNDEBERG:

What about the temperature?

COLONEL BRADISH:

The temperature is very hot in that area.

LT BLANTON:

Under those circumstances I wouldn't want to say just what it would be.

COLONEL BRADISH:

In looking into this thing, there were 16 other classes of personnel who have access to those vessels whose business requires going on the ships; customs officials, immigration officials, FBI, military intelligence, and so on down through the list. We can't apparently enforce immigration on those people. It may be necessary in the end that the Public Health Service will have to set up a Federal requirement for the immunization of these people if the situation is dangerous enough to require it.

LT COLONEL LUNDEBERG:

I don't think it will be dangerous enough for that. I do think that with the people in these categories you mention it might be a voluntary thing and the service obtained from the Army. Specifically I don't know how to answer that, Colonel Bradish. I don't know how lusy these "B" bags are. Does anybody know if the "B" bags are pretty lousy?

COLONEL MELTON:

Gentlemen, we are back to the louse again. In the New York Port, the hold baggage is handled by the Army Transport Baggage Section, and all of these men we recommended they all have typhus innoculations. We also have recommended that the office give innoculations to all of the civilian personnel employed by the Pest Control companies. I believe that is about as far as we have gone.

We have recommended that. Now then, they haven't all had it, but we think it would be wise if they did. I think all the personnel that works with the baggage section of the A.T.S. have been innoculated, but otherwise we haven't done anything further. Now our problem is a little different from some of you. Your baggage is on for 30 days, ours is on about two weeks, which is about time for the louse eggs to hatch out and the lice to be alive when he gets back. But I don't think you have to go too far with that type of innoculation.

COLONEL SCHUHLMANN:

That's right, I don't think there is any great hazard.

COLONEL MELTON:

I think there is very little hazard - very little danger.

LT COLONEL LUNDEBERG:

I do know this. I talked a great deal with Dr. Dyer of the Public Health Service, and he feels pretty well satisfied with the program we have now and he "off the record" said that he was not at all worried about the future. We have a non-lousy population in this country and he can't get too excited about the introduction of typhus. It may be simply because we have an undoubtedly excellent vaccine available in adequate quantities. It may be now we are a little bit too prone to put it in everybody who happens to come within smelling distance of a louse.

LT COLONEL FARR:

The question I would like to raise on that - - we now have a directive out that they will do it when advisable but they won't do too much of it. How about a modification?

LT COLONEL LUNDEBERG:

How does that read?

COLONEL BRADISH:

All permanent personnel aboard in contact with returning troops and prisoners of war. It is fairly broad.

LT COLONEL LUNDEBERG:

Now with respect to those who come in contact with the prisoners themselves --

COLONEL BRADISH:

But what constitutes "contact"? Contact with the baggage in the hold is a danger. On the basis of these I feel I have some moral support at least.

LT COLONEL LUNDEBERG:

I don't think that there is anybody here that is wise enough to know what the danger is.

LT COLONEL FARR:

I have Circular 99 here, pending the publication of more comprehensive instructions. "The known measures for the prevention and control of typhus are prescribed, - a. vaccination; requirements for immunization against typhus are set forth in Section III, AR 40-210 and applied to civilian employees of all Army owned or bare-boat chartered vessels to the same extent that they apply to military personnel." Then there is a little discussion of that and paragraph 2 -- "In addition, all port personnel who may come in contact with lice-infested prisoners-of-war, troops, and other personnel returning from overseas will be similarly vaccinated." Now when the more comprehensive instructions come out, perhaps we can modify this.

LT COLONEL LUNDEBERG:

I doubt if they will ever come out. I think that is plenty broad enough.

LT COLONEL FARR:

Does that cover it? We are running a little bit over our time; we will stop at 12:30 however; in the event it is going to cause anyone any embarrassment for their future appointments, I am making this announcement. We have a very small number of questions left, one of which we can't answer. This is the one we can't answer. It would be of great value to clarify the situation as regards the pools of temporary transport personnel, such as that now at Hampton Roads Port of Embarkation. Can such personnel be used on other ships than the ones for which they were originally designated? Can they be used on any short run ships?

I think the answer is that they can be, but I have got to check that through the personnel people before I can give you a definite answer.

LT COLONEL PADAN:

That is all right; I can give you the answer on that.

LT COLONEL FARR:

Fine.

LT COLONEL PADAN:

As long as they are there, they won't be there very long because too much hell has been raised by the Service Command about them being there. It was right for the first sixty days but the last 90 was the straw that broke the camel's back. You can use them for anything you want, they were sent there primarily to aid with the boats. The New York Port, as I get it, has seen fit to keep those men and to put them to work on the Port, and send some of the Port people out. You can use them for anything you want as long as it is for short runs.

LT COLONEL FARR:

Has a clearly defined policy been formulated regarding the dininfestation of patients including prisoners of war and their personal and home baggage prior to departure from the overseas port? I believe that Colonel Lundeberg answered that one yesterday.

LT COLONEL LUNDEBERG:

But it did not answer it very satisfactorily because I don't think I know if there is such a clearly defined policy.

LT COLONEL FARR:

Can we have such policy?

LT COLONEL LUNDEBERG:

I don't see why not, we certainly should have one.

LT COLONEL FARR:

Will you make every effort to get one?

LT COLONEL LUNDEBERG:

Yes, I will.

LT COLONEL FARR:

Thank you. Next question - if such disinfestation has been accomplished, is it felt that it should be repeated routinely upon arrival in the U.S. or just performed in isolated instances where lice are found? There have been several instances where the ship surgeon - in one case, on a hospital ship, certified there were not infested individuals on board, but where inspection upon arrival at the hospital showed a few cases which had not been detected aboard ship.

LT COLONEL LUNDEBERG:

The policy so far has been to more or less put the burden on the poor port surgeon - the Port Commander - to not require him to delouse everybody, but delouse only those who need delousing. That brings up the problem, how is he to know who needs delousing, if we didn't have some of these in your method of delousing, I suppose a person could be more dogmatic about and say everybody gets deloused either aboard or here, or at both places, but it is the feeling with the louse powder and things we have, that that is not going to be necessary. Everybody in Washington has hesitated to add that, and, of course, that puts mor responsibility on the Port Surgeons who determine who is lousy. I suppose the answer to that has to come through your ship surgeons. Is it possible to have ship surgeons know these things?

COLONEL MELTON:

What personnel do you refer to? Prisoners-of-war or all persons?

LT COLONEL LUNDEBERG:

I refer to the soldiers. Prisioners-of-war are pretty well covered.

COLONEL MELTON:

I think that prisoners-of-war should all be disinfected and they should all have their baggage disinfected, but for the returning prisoners, when they are not lousy, it is necessary. Recently we got over three hundred of a British Field Artillery Regiment and they had their clean, newly pressed uniforms on. If we put their wollen uniforms in there, they would have had a fit. We inspected them and examined them and found that they had no lice, and we gave them a critique. We let them go through. I think you have to use your judgement on that.

LT COLONEL LUNDEBERG:

I would like some expressed opinion from the Port Surgeons.

COLONEL MELTON:

I don't see how the Port Surgeon can avoid a certain amount of responsibility. I don't think we should have an ironbound rule that everybody should be disinfested, because some people don't need it. That is my opinion.

COLONEL BRADISH: You can send the first man aboard as a representative of the Port Surgeon, and the first question that is asked of the Transport Surgeon can be "Has there been any evidence on lice on board of the returning troops?" I think the Transport Surgeon is in an excellent position to know. In the first place he makes a daily inspection of the vessel. In the second place he conducts the sick call. If you have very lousy passengers they are going on sick call because I don't think an American soldier will go around lousy without trying to do something about it. We have no intention of delousing anybody who isn't lousy.

LT COLONEL LUNDEBERG:

I think the attitude of the Surgeon General's office is that we prefer to see an occasional louse or a half of a louse, or three lice, creep through the door, rather than add the enormous burden of delousing thousands and thousands of people. The situation is getting better I think. Our weapons are improving and there is less concern about the whole thing than there has been in the past.

BRIG. GENERAL DE WITT:

One other thing in that same circular you read from (indication to Lt. Col. Farr), it directs all troops will be examined after debarkation for lice and disinfested, which is absolutely impossible in San Francisco. You have men on the piers suffering from a cold and you can't examine men on a pier after they have debarked. I don't think it is intended to imply that way, but that is the wording of it.

LT COLONEL FARR:

Returning troops and other personnel are to be carefully inspected upon debarkation and all infested personnel and their bags promptly disinfested. The bedding, clothing, and baggage of such individuals are to be disinfested by appropriate means.

BRIGADIER GENERAL DE WITT:

That should all be done on the ship before the men debark.

LT COLONEL LUNDEBERG:

I think that is the meaning of that.

COLONEL MELTON:

I think that the term debark could mean while on board or immediately afterwards.

LT COLONEL FARR:

Well, the opening sentence is "upon arrival at the port of debarkation all prisoners-of-war will be disinfested. Returning troops and other personnel are to be carefully inspected." It implies upon arrival, but I don't think it needs to be taken that way. You didn't intend it that way, did you Colonel Lundeberg?

LT COLONEL LUNDEBERG:

No sir. That was intended to put the responsibility upon the Port Surgeon. Whether he wants to line them up on a cold pier or to have a Transport Surgeon on board, a man so good that he can take his word, why that is up to him.

LT COLONEL FARR:

We have one different topic now in the matter of debarkations. This has come up at Halifax too, and that is, the order of debarkation, whether you take your troops off first or whether you take your sick and wounded first. What is the practice of the various ports? How about San Francisco?

BRIGADIER GENERAL DE WITT:

At a joint meeting the other day with my medical officers and the Water Division, they decided to take the patients first and stated the order of the evacuation: ambulatory, non-mental, mental non-disturbed, litter patients, then the insane and violently insane. Before those, however, I should have said officers and nurses. We get them back to the hospital first.

LT COLONEL FARR:

How about Seattle?

COLONEL BECHTEIN:

We have got the trains there and if they are late, then we give the Navy or somebody else the right of way and let the troops clear and analyze the situation. It is according to where we have got to move.

LT COLONEL FARR:

How about Los Angeles?

LT COLONEL WHITE:

We move the patients off first. On Navy ships through courtesy of a general working agreement, the Navy takes their patients off first, and on Army ships, Army patients come off first, in the same order as General DeWitt has described.

LT COLONEL FARR:

How about New Orleans?

COLONEL BRADISH:

Debarkations last. We have to make arrangements with the guard house which receives all evacuations and it requires rather close cooperation with the convoy. We have been fooled so many times and were told the arrival time and they were late--fog intervenes, and we found the personnel tied up in the operation of the convoy and we were very much embarrassed by having them wait around sometimes for four hours. We wait until it actually arrives. Then we give them the hour and it is worked out very nicely. I don't believe it constitutes any great inconvenience.

LT COLONEL FARR:

How about Charleston?

LT COLONEL NIELSON:

General debarkation last unless there is a critical case, in which case we do it first.

LT COLONEL FARR:

How about Hampton Roads?

COLONEL LOWRY:

Our standard procedure is to debark patients first according to the individual cases, with the troop movement. If there are Army patients on the same boat we arrange by the location of the ship and by arrangement with the Naval debarkation that in the Navy area we take our patients off too, and in an Army area, we take their patients off.

LT COLONEL FARR:

How about Boston?

MAJOR GORMAN:

We have attempted to debark both the troops and the patients at the same time. That was the purpose of Colonel Rexroad's question as to how many gangplanks we could put down, where the various facilities for the ships were located, etc. If that is not possible, we will evacuate them last.

LT COLONEL FARR:

I think that at Halifax you had a difficult problem of rail.

MAJOR GORMAN:

Yes, sir, that's correct.

LT COLONEL FARR:

How about New York?

LT COLONEL SCHUHMANN:

In New York we schedule the patients first--that is through troop movement. They will always schedule them first. If there is any delay in the ships and the trains waiting to remove prisoners-of-war and other personnel, we take them last. We also use two gangplanks.

LT COLONEL FARR:

In other words, the general plan is to debark the patients at the most suitable means to the local arrangements and cause them the least inconvenience.

We have one other question raised that we are not going to have time to discuss, because it is pratically a new subject and one that we can discuss for an hour. That is the matter of custom clearance of returning personnel. We have, working on that, two officers in the Movement Division - one of them an international aid, Major Banks, and Major Griffin also gets into it a little bit. They are trying to work out some reasonable uniform and acceptable procedure for the clearance of personnel through the customs. As our load of returning personnel increases, that possible delay is also increasing and may cause some trouble in the future.

We have about reached our slightly overtime time limit and I think it is time to sum up the results of the conference. We covered troop movements and medical problems both. We invited our troop movement officers to attend and participate because of the fact that troop movements and medical responsibilities are very closely allied.

We have been very fortunate to have with us Public Health Service representatives, WSA Representatives, and I think yesterday we had some British Ministry representatives. It is an opportunity and has been an opportunity for these various services to get together on some of their mutual problems.

I am afraid we haven't come out with all the answers we would like to have come out with, but I do believe, we have come out with a much better understanding of what some of the problems are.

The committee on regulations for Transport Surgeons has been set up, Colonel Schuhmann and Major Quinn are on the committee. I would like to have them work with Colonel Fitzpatrick on this job, and the sooner they start the better. If you can start the job immediately and I think probably for the convenience of San Francisco, we should start it immediately, so that Major Quinn can be free to go back to work as soon as possible.

BRIG GENERAL DE WITT:

Yes.

LT COLONEL FARR:

We will look for you then, shall we say, tomorrow morning?

LT COLONEL FITZPATRICK:

I think that Colonel Schuhmann suggested they prefer to work in New York prior to going to Washington.

LT COLONEL FARR:

All right, that is acceptable.

LT COLONEL SCHUHMANN:

I think we can write the thing up here and then bring it down there for approval. All the Port Surgeons who brought a recent issue of their latest instructions to Port Surgeons might leave those with us.

LT COLONEL FARR

Yes, we asked that yesterday, and if between you and Major Quinn you don't have them ---(to the officers) if have not furnished one to either Colonel Schuhmann or Major Quinn, please do so following this session.

Now you have had the minutes of the meeting presented to you each morning. It has been a tremendous job to get those minutes out so quickly. The girls, as well as the enlisted men involved in this task, have worked very hard. We owe them a great deal of thanks for their prompt and efficient handling of this job.

I have been asked by Colonel Dorski that you leave the cover of your notebook here, or your whole notebook, so that they can bring it completely up to date. The are making some revisions in the text and bringing it more up to date, and a complete copy will be mailed to you. However, if you would like to take out this part of the minutes, as you have been furnished them, in order to take them with you, you may do so. Some of the folders have already been taken home apparently. Those who have taken them home have only the first day's minutes. We will be able to furnish additional minutes to supplement those if we know whose are missing. But I want to ask you to leave either your whole book or the cover before you go.

COLONEL SCHLICHTENBERG:

I would like to take this opportunity to thank, in the name of the Surgeon General, the Chief of Transportation for making it possible for representatives of the Surgeon General's Office and myself to be at this very profitable meeting.

LT COLONEL FARR:

Thank you, Colonel Sowichtenberg. We owe a great deal to the Surgeon General for his participation in this conference, without which the meeting would have fallen completely flat. Lieutenant Dowdy and his group have given us very fine service in making arrangements and I am sure we all appreciate everything that they have done.

However, we can't limit ourselves just to the particular individuals, because the New York Port as a whole has done a tremendously fine job in setting up this conference. The administrative details that were worked out by Colonel Dorski; the trip that Colonel Fingarson planned; and the trip through the disinfestation plant which Colonel Melton planned - all in all I would say that the New York Port, and we might go farther and say, that all the organizations here in New York, and Commander Terwilleger have all been a great help to us. Dr. Clesen's discussion this morning was one of the best we have had, and subject he covered was one of particular interest. Dr. Bodet from the Public Health in Washington has been a great help to us, giving his assistance behind the scenes as well as at the meeting. I think we have a rising vote of confidence and thanks to the New York Port for the fine job they did in setting this conference up.

(Applause)

COLONEL BRECHEMIN:

Nobody said anything about thanking Colonel Farr.

(Applause)

COLONEL FARR:

Thank you.

(The conference adjourned at 12:30)